

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 6 3 3

8635301

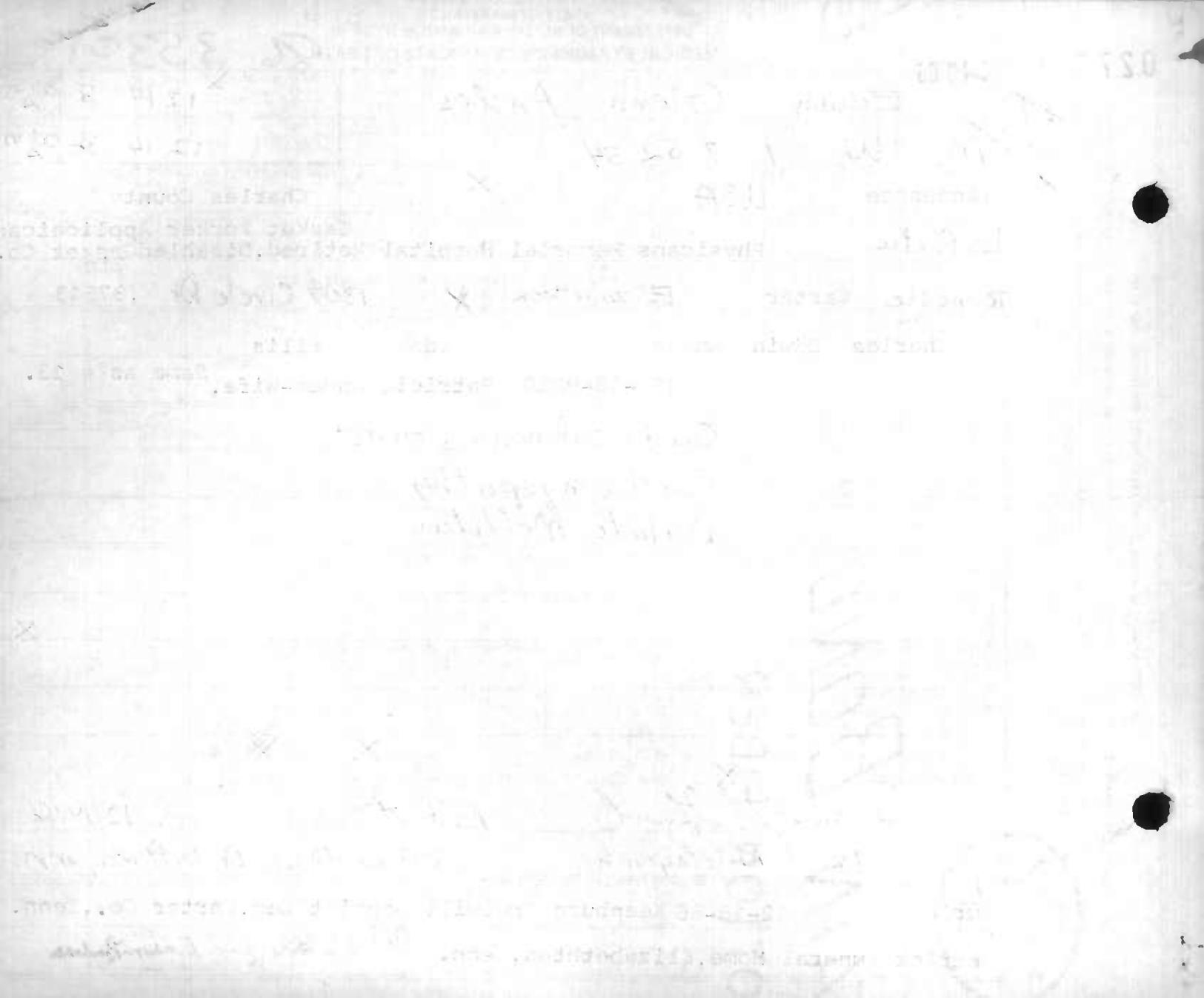
REG. NO.

027590

1- STATE
REG. NO.
EXAMINER'S NAME
(TYPE OR PRINT)
EdwinMIDDLE
LAST
Glenn Andes2a DATE KNOWN
OF ESTI-
MATED
12 14 86
MONTH DAY YEAR
2b HOUR
00 45
AM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

3. DATE OF BIRTH
MONTH DAY YEAR
1 7 52 34
6. AGE (IN YEARS
LAST BIRTHDAY)
YRS.
IF UNDER 1 YR. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.
7b CITIZEN OF WHAT COUNTRY?
USA
8. MARRIED NEVER MARRIED
WIDOWED DIVORCED
9. BALTIMORE CITY OR COUNTY OF DEATH
Charles County10. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Tennessee
11. CITY OR TOWN OF DEATH
La Plata
12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Physicians Memorial Hospital
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Tennessee
13c. COUNTY
Carter
13d. CITY OR TOWN
Elizabethton
13e. STREET ADDRESS
1307 Circle Dr., 37643
14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Edwin Andes
15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Ellis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO
16b. SOCIAL SECURITY NO.
410-88-9810
17. INFORMANT
Patricia Andes-Wife,
ADDRESS Same as # 13.18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
{
(b) Cardiomyopathy
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes MellitusAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY?
YES NO 21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH
21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK
21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE22a. I certify that I took charge of the remains described above, held an
death resulted from Natural causes Accident
Autopsy Inspection Inquiry and in my opinion
Suicide Homicide Undetermined manner ACTUAL
SIGNATURE David N. Gingrich
TITLE (SPECIFY)
M.D. Assistant
MEDICAL EXAMINER
DATE SIGNED 12/14/86EXAMINER'S NAME
(TYPE OR PRINT)
David N. Gingrich
ADDRESS 5019 Woodhaven Dr. La Plata, MD23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial
23b. DATE
12-18-86
23c. NAME OF CEMETERY OR CREMATORIAL
Keenburg Freewill Baptist Cem., Carter Co., Tenn.23d. LOCATION
CITY OR TOWN
COUNTY
STATE24. FUNERAL DIRECTOR
NAME
Tetrick Funeral Home, Elizabethton, Tenn.
ADDRESS25a. DATE RECORD BY DEATH
DEC 18 1986
25b. REGISTRAR'S SIGNATURE
Julia Scadron999999
BP
DHMH - 17
(VR A15 ME (5))
20M 4/82



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be informed of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 3 5 3 0 2				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)		FIRST JENNIE		MIDDLE GERTRUDE		LAST BURCH		2a. DATE OF DEATH December 15, 1986		MONTH YEAR	DAY	YEAR	2b. HOUR 5:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 20, 1904				6. AGE (IN YEARS LAST BIRTHDAY) 82		MONTHS YRS.	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	
7a. BIRTHPLACE COUNTRY New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.						
10. CITY OR TOWN OF DEATH Port Tobacco		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Burch Road, Rt. 1, Box 1162		12a. USUAL OCCUPATION Home maker		12b. KIND OF BUSINESS OR INDUSTRY at Home								
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Port Tobacco		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 1162, Burch Road						
14. FATHER'S NAME FIRST John		MIDDLE Andrew		LAST Hunt		15. MOTHER'S MAIDEN NAME FIRST May		MIDDLE Isabell		LAST Taylor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-22-0785		17. INFORMANT Joseph Stewart Burch-Son		ADDRESS								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coniumma of Colic</i> .										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.														
(b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/13/86</u> to <u>12/16/86</u> , that (I) (we) last saw the deceased alive on <u>12/15/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Khadar Baig, M.D.</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>12/16/86</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Khadar Baig, M.D.		22e. ADDRESS 108 LaGrange Ave; LaPlata, MD 20646												
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/18/86		23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart Cemetery		23d. LOCATION CITY OR TOWN La Plata, Maryland								
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Md.		25a. DATE REC'D. BY REGISTRAR DEC 19 1986		25b. REGISTRAR'S SIGNATURE <i>John E. Ehrhart</i>										

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 3550

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST
ALLEN

MIDDLE

LAST

2a. DATE KNOWN
OF
DEATH
ESTI-
MATED

MONTH
12 18

DAY
19

YEAR
86

2b. HOUR
7 PM

3. SEX

4. RACE
Male

5. DATE OF BIRTH
MONTH DAY YEAR
1 23 21

6. AGE (IN YEARS)
LAST BIRTHDAY
65 YRS

7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN

2c. DATE
PRONOUNCED
DEAD

MONTH
12 18

DAY
19

YEAR
86

2d. HOUR
7 PM

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

NEW MEXICO

10. CITY OR TOWN OF DEATH

LAPLATA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

PHYSICIANS MEMORIAL HOSPITAL

12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
NEW JERSEY

13b. COUNTY
ESSEX

14. FATHER'S NAME

FIRST
ROY

MIDDLE

LAST
CARIDAD

15. MOTHER'S MAIDEN NAME

FIRST
CARMEN

MIDDLE

LAST
GONZALEZ

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

YES
W.W.II

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which

gave rise to immediate

cause (a) stating the under-

lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

Autopsy Inspection Inquiry

and in my opinion

ACTUAL
SIGNATURE

H M Haft

M.D.

Charles C. Haft

MEDICAL EXAMINER

EXAMINER'S NAME
(TYPE OR PRINT)

H M Haft

ADDRESS

1020 Darley Drive Laplata 20646

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE
12-22-86

23c. NAME OF CEMETERY OR CREMATORI

RESTLAND MEM. PARK

23d. LOCATION
CITY OR TOWN

HANOVER

COUNTY

MORRIS

STATE

NJ

24. FUNERAL DIRECTOR
NAME

AREHART FUNERAL HOME, LAPLATA,

DANCY FUNERAL HOME, CALDWELL, NJ 07006

25b. REGISTRAR'S SIGNATURE

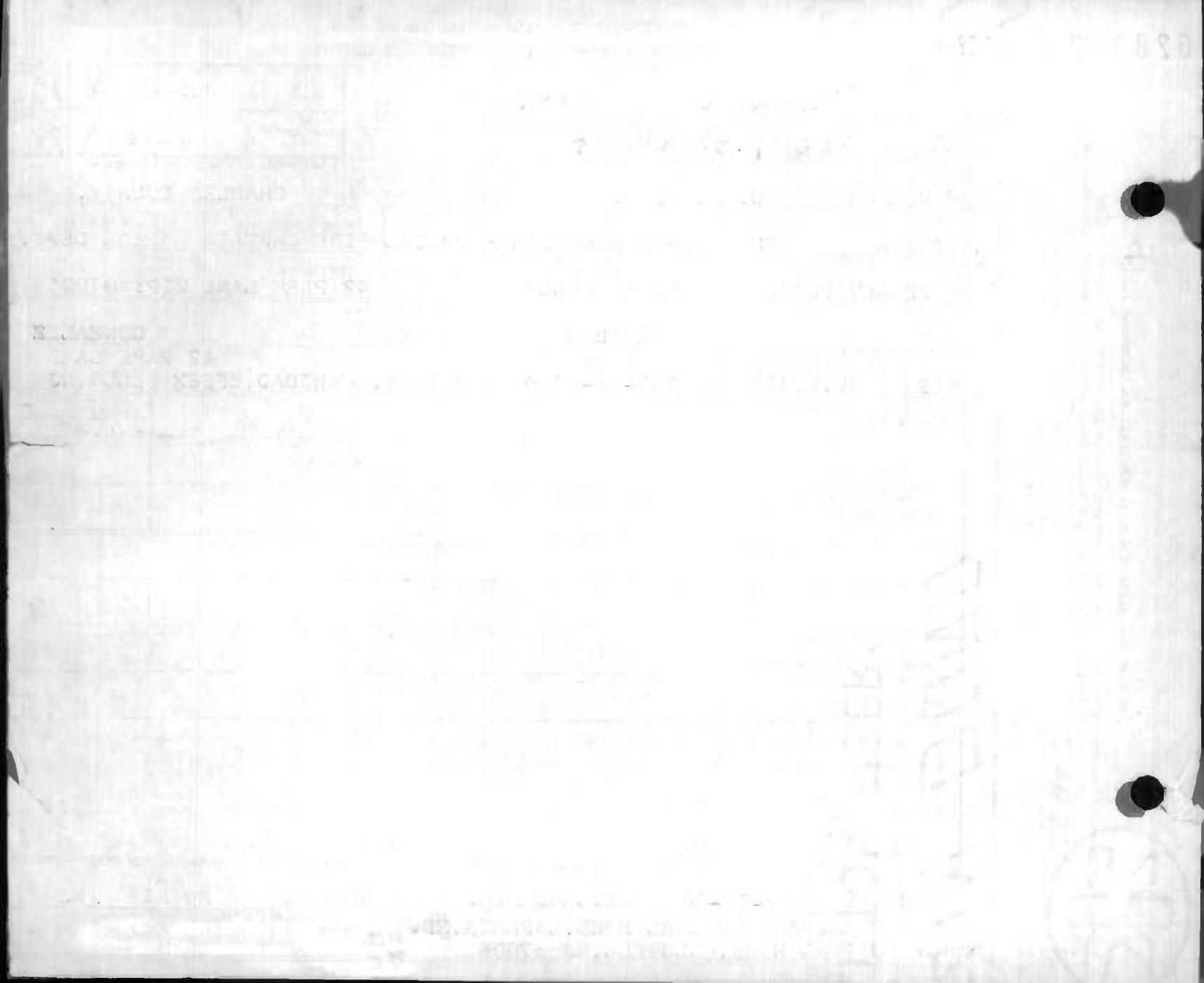
Julia L. Haft

REGISTRAR

12/18/86

DATE

SIGNED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, then

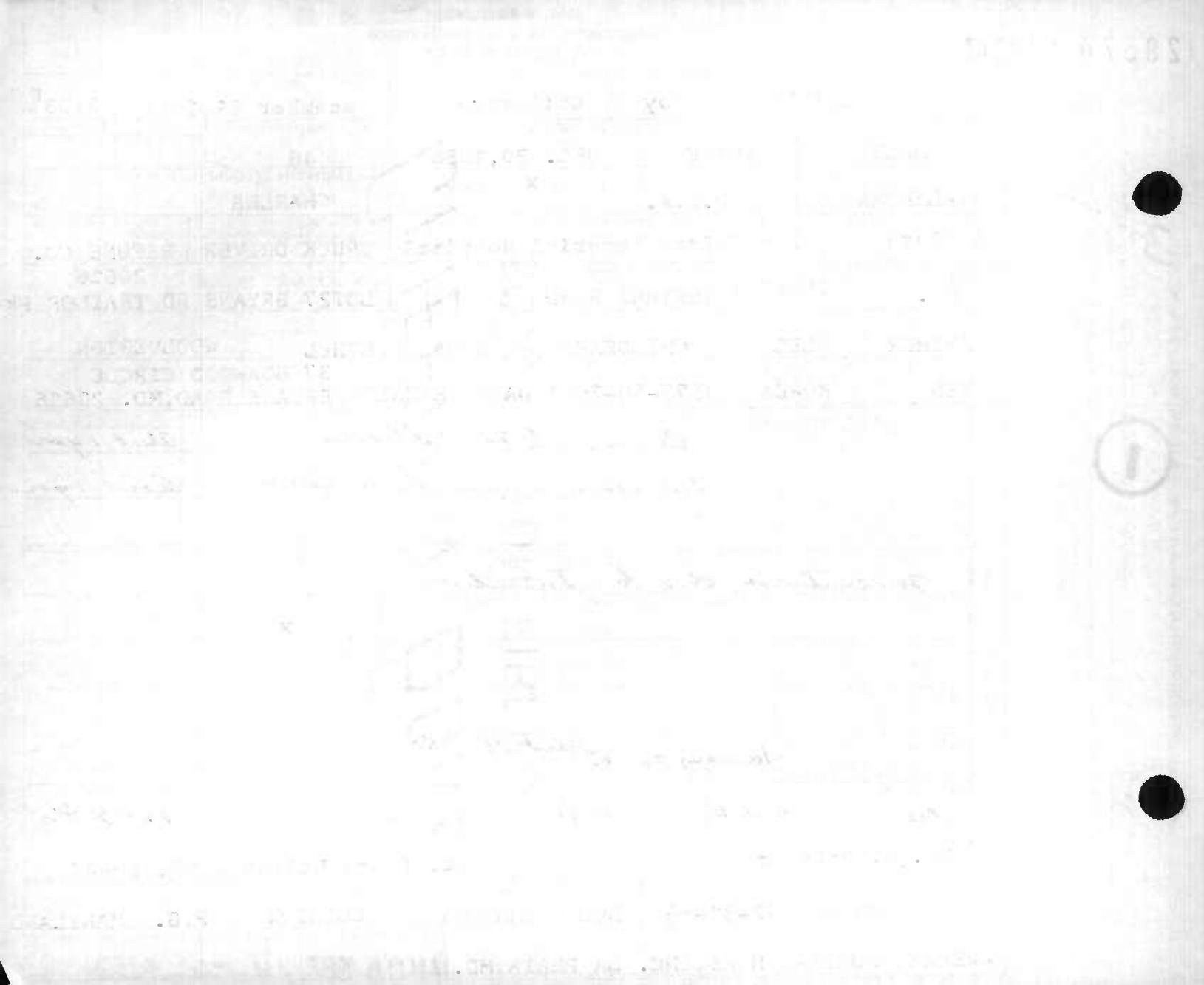
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 3 3 3 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>William Roy Childears</u>			2a. DATE OF DEATH <u>December 29, 1986</u>	MONTH DAY YEAR	2b. HOUR <u>3:03 P.M.</u>
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH <u>DEC.</u> DAY <u>20</u> YEAR <u>1938</u>	6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OKALAHOMA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES		
10. CITY OR TOWN OF DEATH LaPlata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER	12b. KIND OF BUSINESS OR INDUSTRY REFUSE CO.
13a. STATE MD.	13b. COUNTY Charles	13c. CITY OR TOWN BRYANS ROAD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE LOT27 BRYANS RD TRAILOR PK 20616	
14. FATHER'S NAME FIRST ARTHUR	MIDDLE LEE	LAST CHILDEARS	15. MOTHER'S MAIDEN NAME FIRST NINA	MIDDLE ETHEL	LAST WOOLVERTON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) KOREA 577-50-3991	17. INFORMANT DANNY HAINES	37 ADDRESS BOXWOOD CIRCLE BRYANS ROAD, MD. 20616		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of the bladder</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>About 1 year</u>		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastasis Cancer from Colon</u>			<u>About 1 year</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a). <u>Malnutrition due to Inanition</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>March 18, 1985</u> , to <u>19</u> , that (I) (we) lost saw the deceased alive on <u>January 26, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Antonio C de la Paz, M.D.</u>	DEGREE <u>M.D.</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>12-30-86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. DeLapaz	22e. ADDRESS 128 Rt. 6 West LaPlata, Md. 20646				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 12-31-86	23c. NAME OF CEMETERY OR CREMATORIAL LEE CREMATORIAL	23d. LOCATION CITY OR TOWN CLINTON	23e. COUNTY P.G.	STATE MARYLAND
24. FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC.	ADDRESS LA PLATA, MD.	25a. DATE REC'D. BY REGISTRAR JAN 05 1987	25b. REGISTRAR'S SIGNATURE John Doe		



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

363530

REG. NO.

1. DECEASED NAME TYPE OR PRINT			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Nora Wright Cleary						December 25, 1986				10:15 A	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female			Caucasian	MONTH	DAY	YEAR	88	YRS	MONTHS	MONTHS	IF UNDER 24 HRS.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8.			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS	
Maryland			US	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Charles			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
La Plata			Physicians Memorial Hospital			Clerk			Retail		
13a. STATE Maryland						13b. COUNTY Charles	13c. CITY OR TOWN La Plata	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt. 2, Box 2235 / 20646		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST		
Ira N.				Wright	Maude J.				Bowie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS P. O. Box 322 Madolyn Steinhouser La Plata, Md.		
no			577-42-5765						20646		
18. CAUSE OF DEATH (Enter only one cause per line for item 18a and 18b) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC HEART DISEASE</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>RESPIRATORY FAILURE</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>DIFFUSE CEREBRAL DYSFUNCTION; GASTRIC BLEEDING.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
19b.						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that <input type="checkbox"/> (the hospital) attended the deceased from <u>12/25/86</u> , 19 <u>86</u> , to <u>12/25/86</u> , 19 <u>86</u> , that (1) <input checked="" type="checkbox"/> last saw the deceased alive on <u>12/25/86</u> , 19 <u>86</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated (1) <input type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4) <input type="checkbox"/> (5) <input type="checkbox"/> (6) <input type="checkbox"/> (7) <input type="checkbox"/> (8) <input type="checkbox"/> (9) <input type="checkbox"/> (10) <input type="checkbox"/> (11) <input type="checkbox"/> (12) <input type="checkbox"/> (13) <input type="checkbox"/> (14) <input type="checkbox"/> (15) <input type="checkbox"/> (16) <input type="checkbox"/> (17) <input type="checkbox"/> (18) <input type="checkbox"/> (19) <input type="checkbox"/> (20) <input type="checkbox"/> (21) <input type="checkbox"/> (22) 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type="checkbox"/> (922) <input type="checkbox"/> (923) <input type="checkbox"/> (924) <input type="checkbox"/> (925) <input type="checkbox"/> (926) <input type="checkbox"/> (927) <input type="checkbox"/> (928) <input type="checkbox"/> (929) <input type="checkbox"/> (930) <input type="checkbox"/> (931) <input type="checkbox"/> (932) <input type="checkbox"/> (933) <input type="checkbox"/> (934) <input type="checkbox"/> (935) <input type="checkbox"/> (936) <input type="checkbox"/> (937) <input type="checkbox"/> (

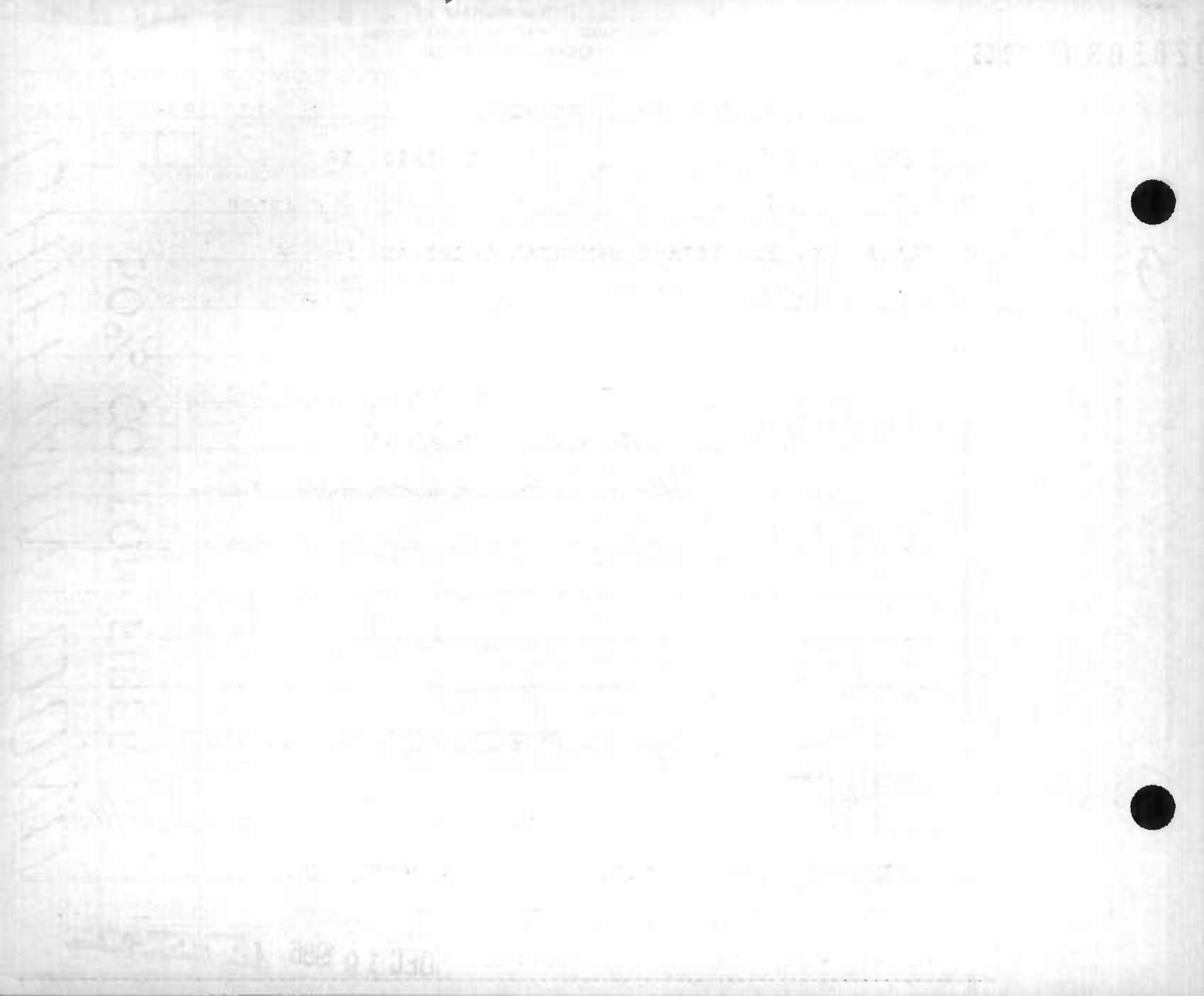
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ✓ show injury, injury, or other traumatic event, the medical examiner may be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
REG. NO. 65																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
VERONICA M. DASHIELL						12	12	1986				P 1:40 M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE			BLACK			MONTH	DAY	YEAR	8	31	1912	74	MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			CHARLES MD.					
MARYLAND			UNITED STATES			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					
LA PLATA, MD. PHYSICIANS MEMORIAL HOSPITAL									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MARYLAND			13b. COUNTY CHARLES			13c. CITY OR TOWN INDIAN HEAD			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 110 Woodland Drive/ 20640					
14. FATHER'S NAME FIRST WILLIAM			MIDDLE GREEN			15. MOTHER'S MAIDEN NAME FIRST ANNIE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT HELEN HART		
NO												18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS INDIAN HEAD, MARYLAND		
												Cordiac Arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
												(b) <u>atherosclerotic cardiovascular disease</u>					
												(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (I) (has/had) attended the deceased from 1984 19 to 12/12/86 19, that (I) (we) last saw the deceased alive on 12/12/86 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												22c. DATE SIGNED 12/14/86					
22b. SIGNATURE T. PACE						DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TIMOTHY PACE M.D.						22e. ADDRESS WALDORF, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 17, 1986			23c. NAME OF CEMETERY OR CREMATORIUM ST. CHARLES CEMETERY			23d. LOCATION CITY OR TOWN GLYMONT			COUNTY CHARLES	STATE Md.				
24. FUNERAL DIRECTOR NAME THORNTON'S FUNERAL HOME			ADDRESS POMONKEY, Md.			25a. DATE REC'D. BY REGISTRAR DEC 19 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendleton								
DMMH - 16 60M 7/84 (VRA 15, 4)																	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1, RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF INFECTIOUS DISEASES, 201 W. PRESTON STREET, BALTIMORE, MD 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

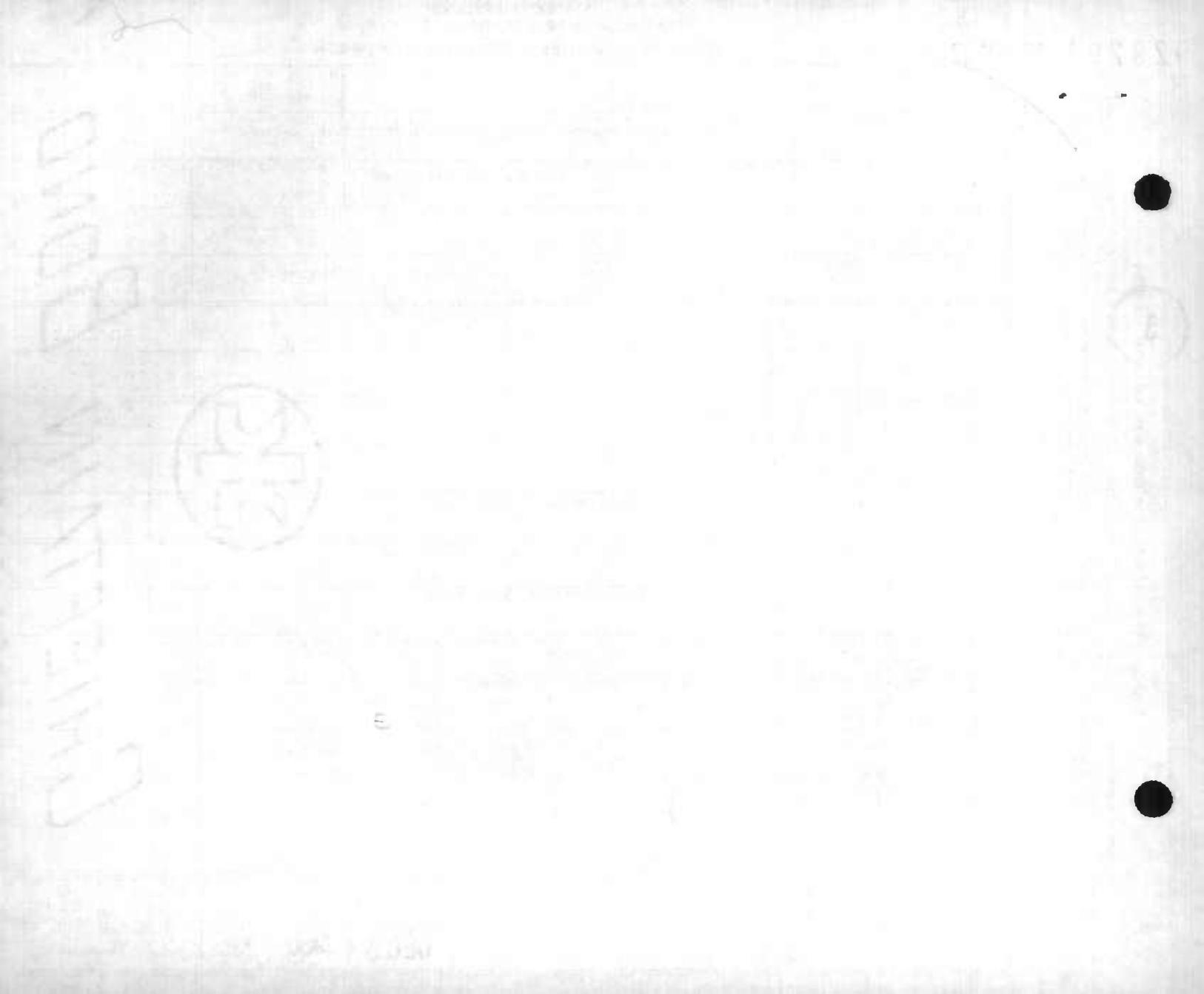
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE (MD-22301)

DECEDENT'S NAME (TYPE OR PRINT)						RECD. NO.					
Charlotte			Jean Day			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE IN YEARS LAST BIRTHDAY	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2b. DATE MONTH	DAY	YEAR	2b. HOUR M		
Female	Cauc.	10-18-1930	56 yrs.	MONTHS	DAYS	HOURS	MIN.		2d. HOUR 4:06 P.M.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.	
West Virginia		US									
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician's Memorial Hospital			12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE) Housewife					12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 105 Estelle Ct./21784				
14. FATHER'S NAME FIRST Brady		MIDDLE		LAST Lemley	15. MOTHER'S MAIDEN NAME FIRST Fredia		MIDDLE			LAST Todd	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. no		16c. SOCIAL SECURITY NO. 233-46-8249		17. INFORMANT Phillip S. Day		ADDRESS 290 Pam Dr. Waldorf, Md. 20601			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8121 IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <u>3:42</u> MONTH <u>12</u> DAY <u>27</u> YEAR <u>1986</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject passenger in auto/auto collision		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET Rt. #225 & Rt. #301, Charles County, Md.		CITY OR TOWN			COUNTY		
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Dennis F. Smith, M.D.</u>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>		TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 12/28/86	
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smith, M.D.			ADDRESS 111 Penn St.						
23a. BURIAL, CREMATION, REMOVAL [SPECIFY] Burial		23b. DATE 1-2-87		23c. NAME OF CEMETERY OR CREMATORIAL Ioof Cemetery		23d. LOCATION CITY OR TOWN Parkersburg, West Virginia		COUNTY			STATE
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		P. O. Box 156 ADDRESS Waldorf, Md. 20601		25a. DATE REC'D. BY REGISTRAR DEC 31 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Seidenberger</u>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, TO FUNERAL DIRECTOR: PAGE 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												3 5 3 0							
												REG. NO.							
DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a DATE KNOWN OF ESTI- MATED		MONTH	DAY	YEAR	2b HOUR					
Keith			Edwin			Day			<input checked="" type="checkbox"/>		12/	27	86	M					
3a SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS			7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		10. MONTH DAY YEAR		11. HOUR 4:30 P M			
Male	Cauc.	11-6-1930			56			MONTHS		DAYS		HOURS		MIN.		12/ 27 86		12. HOUR 4:30 P M	
16. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
West Virginia			US						Charles County, MD										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY Religion										
La Plata			Physician's Memorial Hospital			Minister													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS								
Maryland			Carroll			Sykesville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		105 Estelle Ct./21784								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST										
John			Owen			Day			Susie										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS										
yes			1948-1950			234-36-3101			Pam Drive										
8120			IMMEDIATE CAUSE (a)			Multiple Injuries													
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.			{ (b)			DUE TO, OR AS A CONSEQUENCE OF													
{ (c)			DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
3:42 P.M. 12/ 27/86			subject driver of auto/auto collision																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION													
			roadway			Rt. 225 & Rt. 301, Charles County, Md.													
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Dennis F. Smith, M.D.</i>												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
												TITLE (SPECIFY) Assistant MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)			Dennis F. Smith, M.D.			ADDRESS			DATE SIGNED 12/28/86										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY				23f. STATE				
Burial			1-2-87			Ioff Cemetery			Parkersburg		West Virginia								
24. FUNERAL DIRECTOR NAME			ADDRESS			P. O. Box 156			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Huntt Funeral Home						Waldorf, Md. 20601			DEC 31 1986		<i>Julia Dawson Randas</i>								
DMMH - 17 (VR A15 ME (5))																			



026530 DEC-9-86

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be

resigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use at the burial facility. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 20 shows any injury, or other automatic agent, the medical

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86333

REG. NO.

1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR										2b. HOUR		
DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			12-01-86		4:55PM	
ALFRED SANFORD DUERSON															
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
MALE			WHITE			SEPT. 21. 1924			62 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			CHARLES COUNTY MD.			
VIRGINIA			U.S.A.												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. ADDRESS OF WORK (IF MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			12. STREET ADDRESS / ZIP CODE			
LAPLATA, MD.			PHYSICIANS MEMORIAL HOSPITAL						ARCHITECT			OF CAPITOL ST. RT. 1 BOX 1309 A 20677		U.S.GOV'T.	
13a. STATE			13b. COUNTY			14. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MARYLAND			CHARLES			PORT TOBACCO									
14. FATHER'S NAME			15. MOTHER'S MIDDLE NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
LAWRENCE			MINNI MIDDLE WISE			229-16-8975			JEAN A. DUERSON			SAME AS #13			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			16b. SOCIAL SECURITY NO.			16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
WWII															
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III)			19. DUE TO, OR AS A CONSEQUENCE OF (b)			20. DUE TO, OR AS A CONSEQUENCE OF (c)			21. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN			21h. COUNTY		21i. STATE	
22a. I certify that (I) (this hospital) attended the deceased from now until deceased died on 19-86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.			22b. SIGNATURE G. J. WADDELL			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12-1-86						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) G. J. WADDELL			22f. ADDRESS WADDELL, MD 20601			22g. ADDRESS			22h. LOCATION CHELTENHAM P.G. Md.						
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE Dec. 5 1986			23c. NAME OF CEMETERY OR CREMATORIAL Md. VETS. CEM.			23d. LOCATION CITY OR TOWN						
24. FUNERAL DIRECTOR AREHART FUNERAL HOME INC., LA PLATA Md.			25a. ADDRESS AREHART FUNERAL HOME INC., LA PLATA Md.			25b. DATE REC'D. BY REGISTRAR DEC 8 1986			25c. REGISTRAR'S SIGNATURE Julia Dandrea						

029442 JAN - 3 07

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

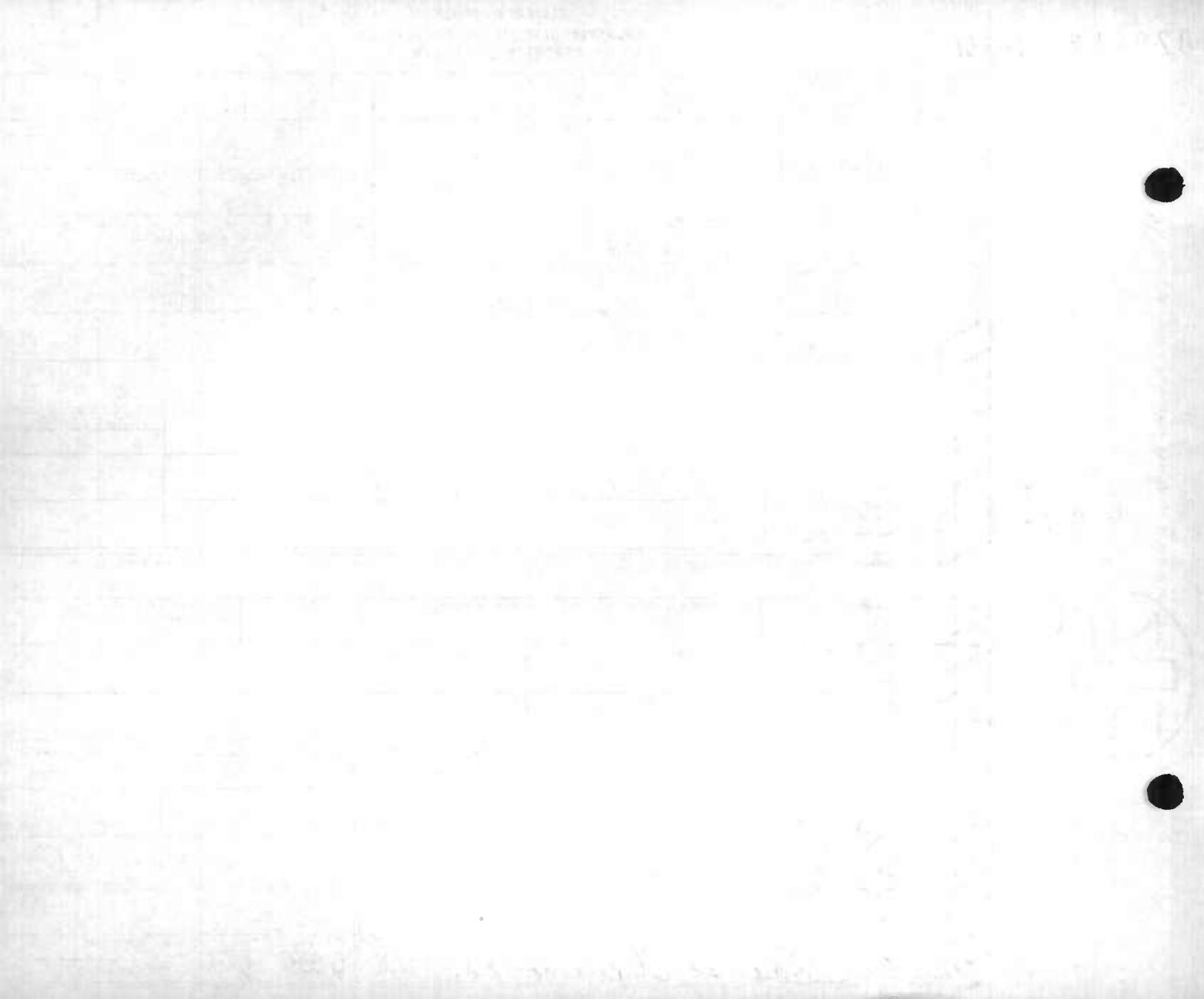
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Francis E. Farmer							12	20	86					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		Black		MONTH 11	DAY 23	YEAR '13	73			MONTHS YRS.	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA					Charles							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hughesville		P.O. Box 291					Mechanic			MD.				
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Hughesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. Box 291		20637				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST							
James		F.	Farmer	Mary		Florence	Wade							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 213 01 2450				17. INFORMANT Christine Farmer SAA						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma Stomach</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>3-14-1986</i> to <i>12-20-1986</i> , that (I) (we) last saw the deceased alive on <i>12-7-1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED		
22b. SIGNATURE <i>W. S. Rath</i>		22c. DEGREE <i>M.D.</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. S. RATH, M.D.</i>		22e. ADDRESS <i>CHAS. PROF. CTR. WALDOORF, M.D.</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 12/27/86		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cath Ch			23d. LOCATION CITY OR TOWN Bryantown, Chas., Md.		23e. COUNTY STATE					
24. FUNERAL DIRECTOR NAME <i>Martell Adams, Aquasco, Md.</i>		ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 5 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner may be notified of same.



027608 DEC 19 1986
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

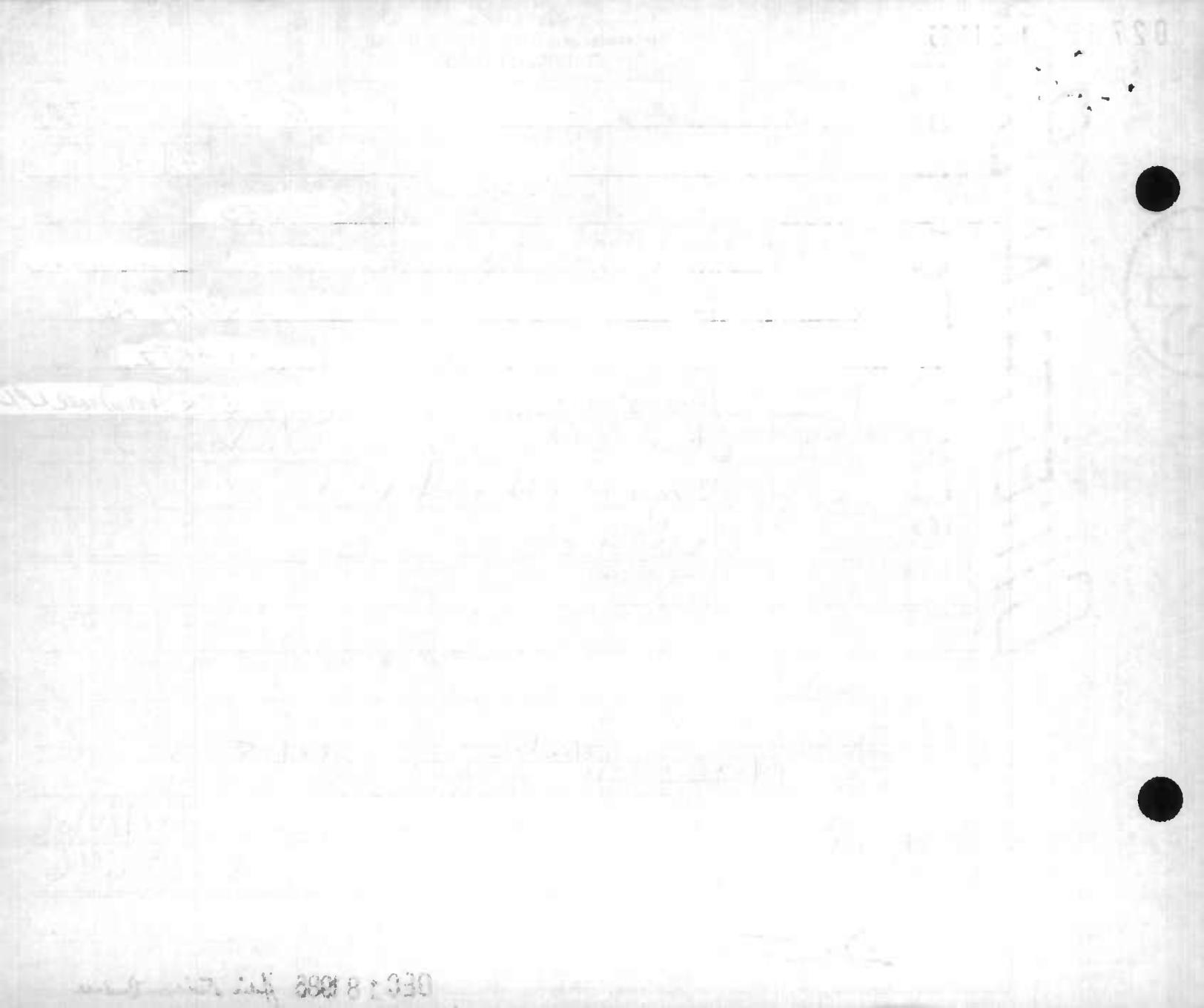
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mildred Bowen Gabriel				2a. DATE OF DEATH MONTH DAY YEAR December 15, 1986	2b. HOUR 9:45 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 11, 1906	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	7. IF UNDER 1 YEAR MONTH DAY HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Maryland		13b. COUNTY A A Co.		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1250 Dorothy Road 21032	
14. FATHER'S NAME James H.		15. MOTHER'S MAIDEN NAME Dunnila		16. MOTHER'S MAIDEN NAME Mary Breehl	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? No		17b. SOCIAL SECURITY NO. NA		17c. INFORMANT (Daughter) ADDRESS Mrs. Marilyn A. Schwartz Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a) DUE TO, OR AS A CONSEQUENCE OF <i>Chronic Myelogenous Leukemia</i> Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF <i>Congestive Heart Failure</i> <i>Chronic Leukemia</i>					
19. MEDICAL CERTIFICATION PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (1) (this hospital) attended the deceased from 12/16/86 to 12/15/86, that (1) (we) lost sow the deceased alive on 12/10/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death					
22b. SIGNATURE <i>Dr. J. H. Watson</i>		DEGREE		22c. DATE SIGNED 12/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. WATSON		22e. ADDRESS La Plata and 20646			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 19, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Mount Emblem	23d. LOCATION CITY OR TOWN Elmhurst,	23e. COUNTY STATE Du Page Ill.
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 18 1986	25b. REGISTRAR'S SIGNATURE <i>Jim Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. It should be retained by the funeral director, page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section should be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 36 53 4									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
FRANCIS		m.		Greenfield				11 26 1986		11:06 ^a	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
Male		Black		1 27 1901		85 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		USA				Charles County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
La Plata		Physicians Memorial Hosp.		Farmer							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Prince Geo		Upper Marl.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		P.O. Box 3652		20772	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
John				Greenfield		Winifred				Edelen	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
unknown		217 16 0139		Robt. Pickerl		Box 137 Hwy 382 Waldorf, Md. 20601					
18. CAUSE OF DEATH (Enter only one cause per line for each, and enter in Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a), DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b), DUE TO, OR AS A CONSEQUENCE OF (c))											
19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 1985, 19 to 1986, 19, that (1) (we) last saw the deceased live on 11/20/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.											
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Ward M. Adams		11/21/86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		12/1/86		Resurrection Cem		Clinton, P.G., Md					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Martell Adams, Aguasco-Md 20608				DEC 4 1986		Julia Sciamone					



027934-DOC2086
12086
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

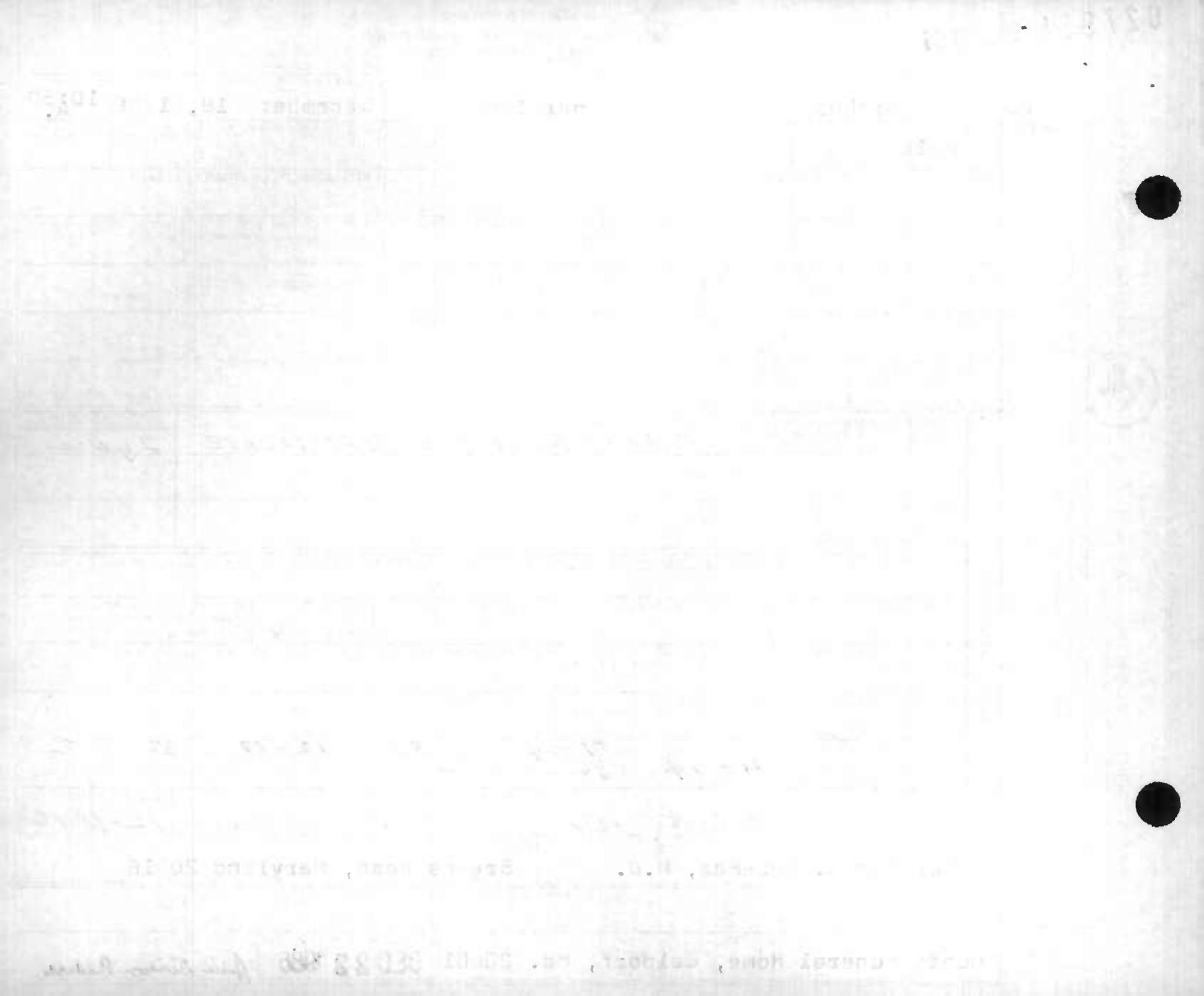
REG. NO. 30 35 31 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST Arthur	MIDDLE Leicester	LAST Harrison Sr.	2a DATE OF DEATH December 18, 1986	MONTH 12	DAY 18	YEAR 1986	2b. HOUR 10 A.M.				
3. SEX Male			4. RACE Caucasian	5. DATE OF BIRTH MONTH 9-20-1937 YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles			MD.		
10. CITY OR TOWN OF DEATH Bryans Road			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2, Box 171C, Fenwick Rd			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Auto					
13a. STATE Maryland			13b. COUNTY Charles			13c. CITY OR TOWN Bryans Road			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 2, Box 171C/20616		
14. FATHER'S NAME FIRST Robert			MIDDLE Irving			LAST Harrison			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE Elizabeth	LAST Lowery	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---			17. INFORMANT Jean Marie Harrison			ADDRESS same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			CANCER OF THE SOFT PALATE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years		
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (we) attended the deceased from 01-04 1985, to 12-17 1986, that (I) (we) last saw the deceased alive on 11-14 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Aurelio C. DeLaPaz, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-18-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aurelio C. DeLaPaz, M.D.			22e. ADDRESS Bryans Road, Maryland 20616											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-20-86			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial			23d. LOCATION CITY OR TOWN Waldorf, Chas., Md.			COUNTY	STATE	
24. FUNERAL DIRECTOR Huntt Funeral Home, Waldorf, Md. 20601			P. O. Box 156			25a. DATE REC'D. BY REGISTRAR DEC 22 1986			25b. REGISTRAR'S SIGNATURE Julia Deidorn-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 shows any injury, or other traumatic event, the medical examiner must be notified.



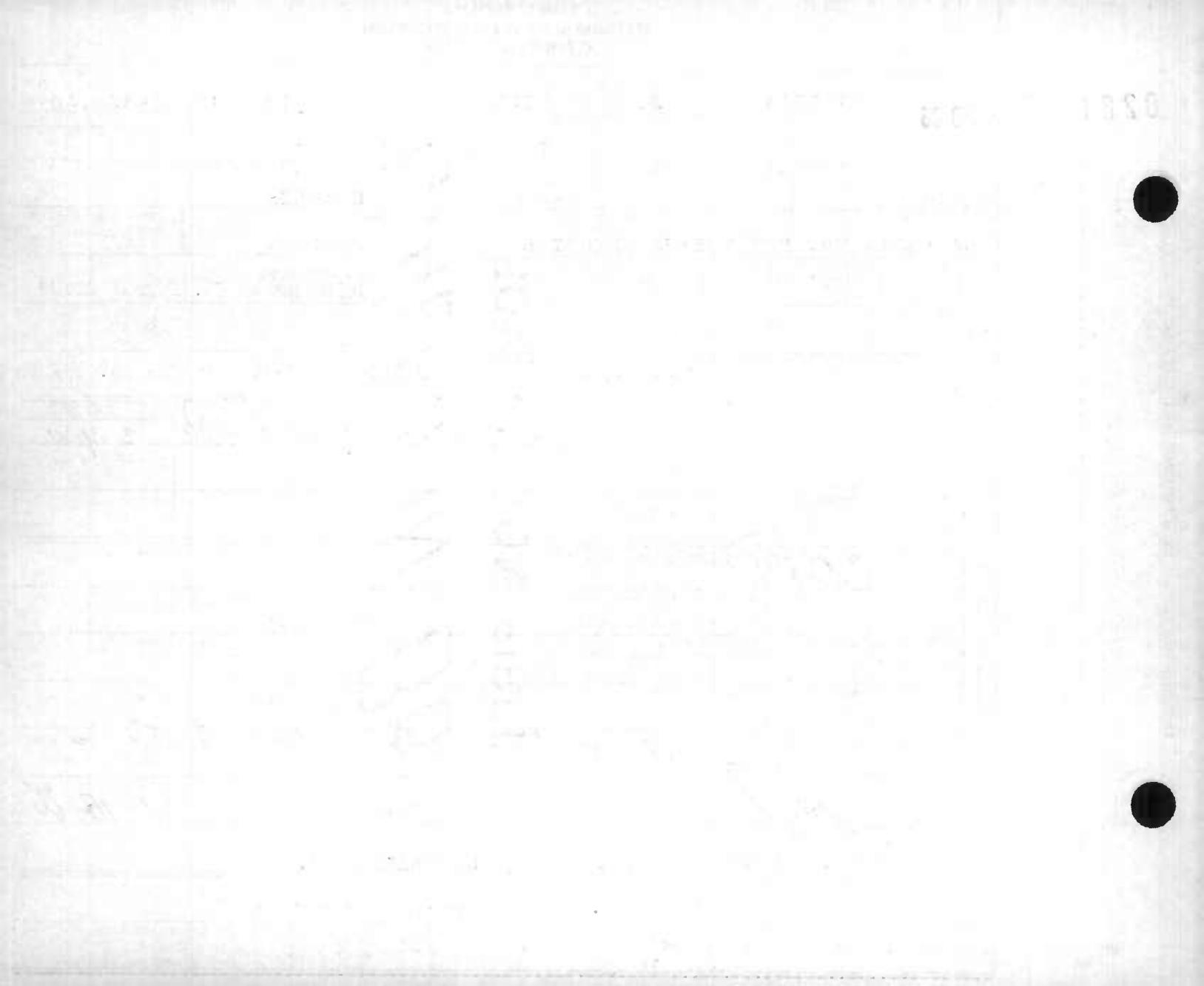
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with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be informed of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 6 3 5 3 1 4								
1 - FOR STATE REGISTRAR											REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
LILLIAN			J.			HILL						12	19	1986	8.40	a				
Y-SEX 10-08-86			4. RACE			white			5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female									MONTH 7 DAY 30 YEAR 1906			80 YRS			MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Washington												CHARLES								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			LA PLATA MD. PHYSICIANS MEMORIAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			housewife			12b. KIND OF BUSINESS OR INDUSTRY					
Maryland			12b. PHYSICIANS MEMORIAL												N/A					
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			14. FATHER'S NAME					
Maryland			Towson			George Stewart						3430 Andrew Ct. Laurel 20708			Elmer FIRST					
14. FATHER'S NAME			MIDDLE			Stewart			15. MOTHER'S MAIDEN NAME			Alice			MIDDLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. ADDRESS			17. INFORMANT			Sherry Fraundorfer 7715 Twin Oak Rd. Severn MD			21144					
NO			579-74-4565																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															(b)					
															(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12-8-1986 to 12-18-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																				
22b. SIGNATURE															DEGREE					
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															22d. DATE SIGNED					
22d. ADDRESS			DANIEL HOWELL M.D.			LA PLATA, MD.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			COUNTY		STATE						
Burial			12/22/86			Mt. Olivet Cemetery			Washington DC											
24. FUNERAL DIRECTOR Donald V. Borgwardt 4400 Powder Mill Rd. Beltsville 20705															25a. DATE REC'D. BY REGISTRAR					
															25b. REGISTRAR'S SIGNATURE					
															Julie D. Robinson, R.R. 1					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/tranfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other trauma, and the medical examiner, the medical examiner must be notified in

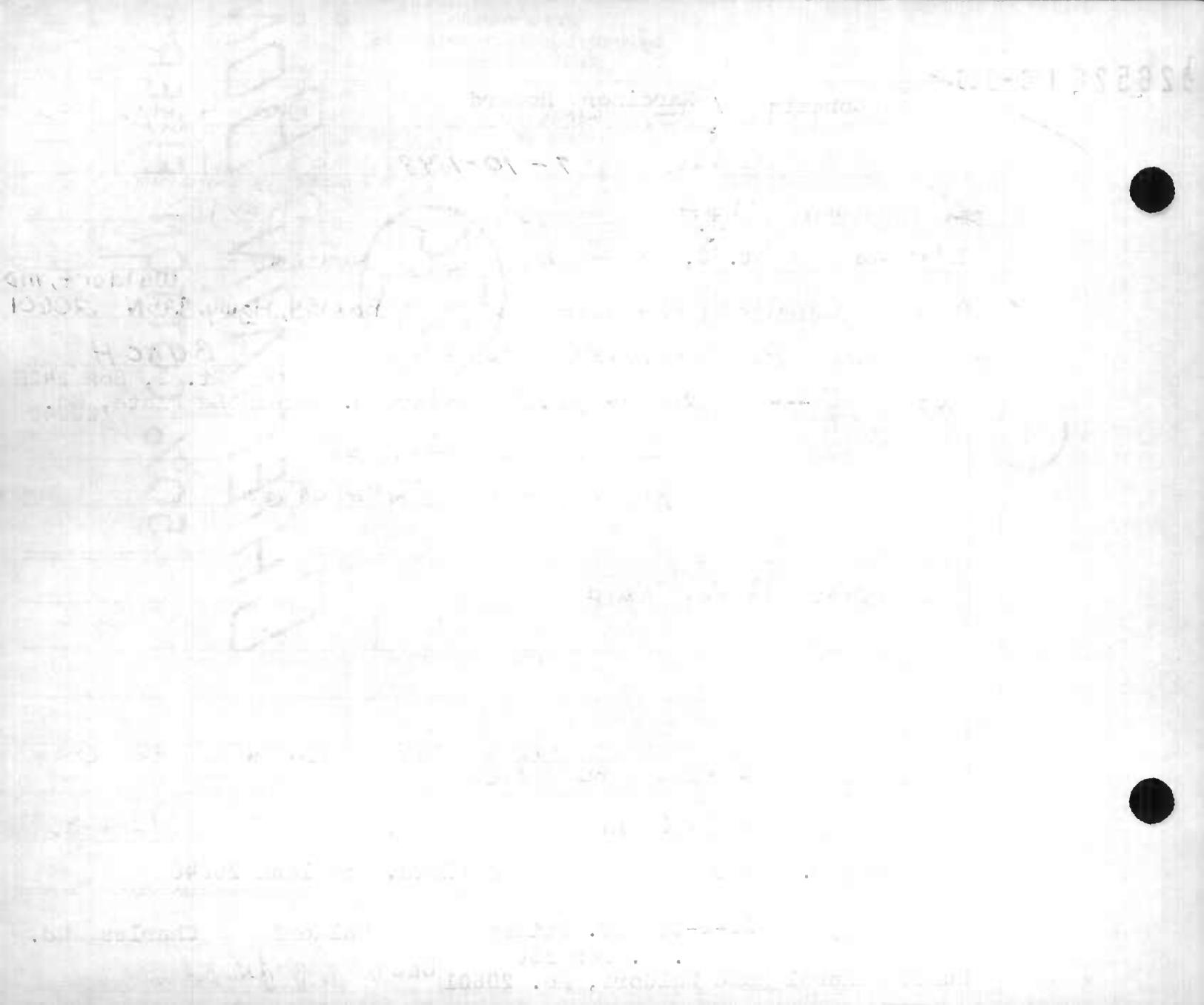
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 35315

1 - STATE
REGISTRAR

REG. NO.

1a. DECEASED NAME FIRST Loretta MIDDLE Gardiner LAST Howard				2a. DATE OF DEATH Dec. 4 1986	MONTH	DAY	YEAR	2b. HOUR 905 PM	
3. SEX F	4. RACE CAUC	5. DATE OF BIRTH MONTH 7 DAY 10 YEAR 1898	6. AGE (IN YEARS LAST BIRTHDAY) 88				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 3, Box 242 H				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY CHARLES		13c. CITY OR TOWN WALDORF		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Box 154, Hwy. 925N 20601	
14. FATHER'S NAME Aloysius B.		MIDDLE GARDINER		LAST		15. MOTHER'S MAIDEN NAME ALVERTA		LAST BURCH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. ---		17. INFORMANT		ADDRESS Rt. 3, Box 242H		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST									
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cardiac Arrhythmia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from May 10, 1977, to Dec 4, 1986, that (we) last saw the deceased alive on 12-4-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did/did not) view the body after death.									
22b. SIGNATURE Henry L. Burke		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-4-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry L. Burke		22e. ADDRESS La Plata, Maryland 20646							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-6-86		23c. NAME OF CEMETERY OR CREMATORIAL St. Peters				23d. LOCATION CITY OR TOWN Waldorf	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		ADDRESS Box 156		25a. DATE REC'D. BY REGISTRAR DEC 8 1986				25b. REGISTRAR'S SIGNATURE Julie S. Burke	
Huntt Funeral Home		Waldorf, Md. 20601							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Please reserve carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial or cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - FOR STATE REGISTRAR			REG. NO. 35316								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 11 30 AM		
MARTHA SARAH JACQUES						Dec 19 1986					
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR JAN 22 98			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		
7a. BIRTHPLACE COUNTRY Johnson Minn			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES		
10. CITY OR TOWN OF DEATH LA PLATA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN 13b, GIVE STREET ADDRESS) MERIDIAN NURSING CEN.			12a. USUAL OCCUPATION Manager and Adminstrator-Retired			12b. KIND OF BUSINESS OR INDUSTRY Fund Raising		
13a. STATE Md.			13b. COUNTY CHARLES			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Chapmans Landing Road RT 22 Box 177-6 20640		
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT W. GREEN			15. MOTHER'S M AIDEN NAME FIRST MIDDLE LAST LYDIA C. WESTPHAL			17. INFORMANT same as # 13. Robert Allen Jacques-Son					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 538-32-0694			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) -Cancer Intestinal Tract 1 ^o undetected 1 month			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)								
(c)			DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Organic brain disorder											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12-17-86 to 12-18-86, that (I) (we) lost above (we) (we) did (did not) view the body after death.											
22b. SIGNATURE Daniel Howell, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-19-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Howell, M.D.			22e. ADDRESS La Plata, Maryland 20646								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/20/86			23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory			23d. LOCATION CITY OR TOWN Clinton, Maryland		
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Md.						25a. DATE REC'D. BY REGISTRAR DEC 23 1986			25b. REGISTRAR'S SIGNATURE Julie Dixon-Lindbeck		
ADDRESS											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return the certificate to the physician. Page 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other significant condition contributing to death, attach a separate sheet.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 66 353 17				
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
X GEORGE JENIFER					12-5-86			2:54 M	
3. SEX MALE	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11/04/1900			6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.				
10. CITY OR TOWN OF DEATH LA PLATA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS) PHYSICIAN MEMORIAL HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Charles	13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Hwy 232 Box 258 20601			
14. FATHER'S NAME John	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Susie			MIDDLE	LAST	Banks	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 218-36-6351			17. INFORMANT Harriett Chapman			ADDRESS Hwy 232 Box 257 Md. 20601		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Dese</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of the Prostate</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R. Timothy Pace</u>	DEGREE MD	ATTENDING PHYSICIAN	<input type="checkbox"/> MEDICAL DIRECTOR	<input type="checkbox"/> STAFF PHYSICIAN	22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS								
R. Timothy Pace, M.D.					Rt. #301 Waldorf, Maryland 20601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/10/86	23c. NAME OF CEMETERY OR CREMATORIAL St Mary's Cath Ch			23d. LOCATION CITY OR TOWN Bryantown, Chas., Md.	COUNTY	STATE		
24. FUNERAL DIRECTOR NAME <u>Martell Adams, Aquasco Inc.</u>	ADDRESS 20601	25a. DATE REC'D. BY REGISTRAR DEC 10 1986			25b. REGISTRAR'S SIGNATURE <u>Janice Davis</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

02771-1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner (or coroner) should be notified.

35318

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR a.m.				
DECEMBER 1986		Olga Thee Jenkins				December 18, 1986		12:42							
15		3. SEX Female.		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 11-09-01		6. AGE (IN YEARS LAST BIRTHDAY) 85		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
15		7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles		MD.					
15		10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing Agt. - US Gov't		12b. KIND OF BUSINESS OR INDUSTRY							
15		13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Indian Head		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 210 20640					
15		14. FATHER'S NAME FIRST Oswald		MIDDLE L.		LAST Thee		15. MOTHER'S MAIDEN NAME Mathilde		MIDDLE		LAST Tietjen			
15		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Eugene A. Jenkins, Jr. Indian Hd., Md.		ADDRESS RFD 1, Box 153							
15		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irreversible Respiratory arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Maranis Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3m 40 hours			
15		DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cerebrovascular Cardiovascular disease 10 yrs</u>													
15		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Diabetes, non insulin dependent</u>													
15		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
15		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
15		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Dec 17 1986		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
15		22a. I certify that (I) (this hospital) attended the deceased from <u>March 29, 1979</u> to <u>Dec 17, 1986</u> , that (I) (we) last saw the deceased alive on <u>Dec 17, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 12-18-86			
15		22b. SIGNATURE <u>Arthur O. Woody, M.D.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
15		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur O. Woody, M.D.		22e. ADDRESS La Plata, Md. 20646											
15		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-20-86		23c. NAME OF CEMETERY OR CREMATORY St. Josephs Ch. Cem Pomfret, Chas., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE							
15		24. FUNERAL DIRECTOR NAME Huntt Funeral Home		P. O. Box 156 ADDRESS Waldorf, Md. 20601		25a. DATE REC'D. BY REGISTRAR DEC 19 1986		25b. REGISTRAR'S SIGNATURE <u>John Tindall</u>							

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

027551

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 4. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 3 RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT REPORT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		2b. MONTH	2b. DAY	2b. YEAR	REG. NO.		
Michael		Raymond		Johnson				<input type="checkbox"/>		12	13	86	0704		
1. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1YR. MONTHS	8. IF UNDER 24 HRS. DAYS	9. HOURS	10. MIN.	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR 12 HOUR 0718		
M	Black	6 1 63	23					<input type="checkbox"/>		12	13	86	A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		CHARLES					
ENGLAND		U.S.A.		<input type="checkbox"/>		<input type="checkbox"/>		CHARLES		MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
La Plata		PHYSICIANS MEMORIAL HOSPITAL						MAIL HANDLER		MAILING CO.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
MD		Charles		La Plata		<input type="checkbox"/>		P.O. Box 328		20646					
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
JEFFREY		L.	JOHNSON	BARBARA		NO		215-94-4197		JEFFREY L. JOHNSON		SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Respiratory Failure							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF													
		(b) DUE TO, OR AS A CONSEQUENCE OF						Amyotrophic Lateral Sclerosis							
		(c)													
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
								<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>						and in my opinion							
ACTUAL SIGNATURE <i>David N. Gingrich</i>		TITLE (SPECIFY) M.D. <i>Assistant</i>						MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS						DATE SIGNED <i>12/13/86</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE					
BURIAL		12-15-86		MD. VETERANS CEM.		CHELTENHAM		P.G.		MARYLAND					
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
AREHART FUNERAL HOME, INC. LA PLATA, MD.								DEC 17 1986		<i>Julia S. Gordon-Randall</i>					
BP															
DHMH - 17 (VR A15 ME (5)) 20M 4/82															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attorney and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or travel.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other trouble with the medical certificate, notify the medical director.

MEDICAL CERTIFICATION

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Manuel E. Jordan						December 19, 1986				2:12 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		BLACK		MONTH	DAY	YEAR	74	MONTHS	YEARS	HOURS	MIN.
JUNE 12, 1912		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		Charles		MD.			
VIRGINIA		UNITED STATES		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X		10. CITY OR TOWN OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
La Plata		Physicians Memorial Hospital		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MARYLAND		CHARLES		INDIAN HEAD		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X		ROUTE 1 Box 84R/ 20640			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
		JOHN	EDWARD	TUCKER	FIRST MARIA		LAST JORDAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES		WWII		214-16-7523		Route 2 Box 2265 Barbara A. Washington La Plata, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF (b)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
				DUE TO, OR AS A CONSEQUENCE OF (c)							
20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12-19-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Girija S. Rath, M.D.</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		St. Charles Prof. Bldg., #3200 Waldorf, Md. 20601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY	STATE		
BURIAL		12-23-86		Md. Veterans Cem.		Cheltenham		P.G.	Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
THORNTON FUNERAL HOME		POMONKEY, MD.		DEC 24 1986		<i>Julie Davidson-Pendell</i>					

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 35321

029634 JAN 18 1987

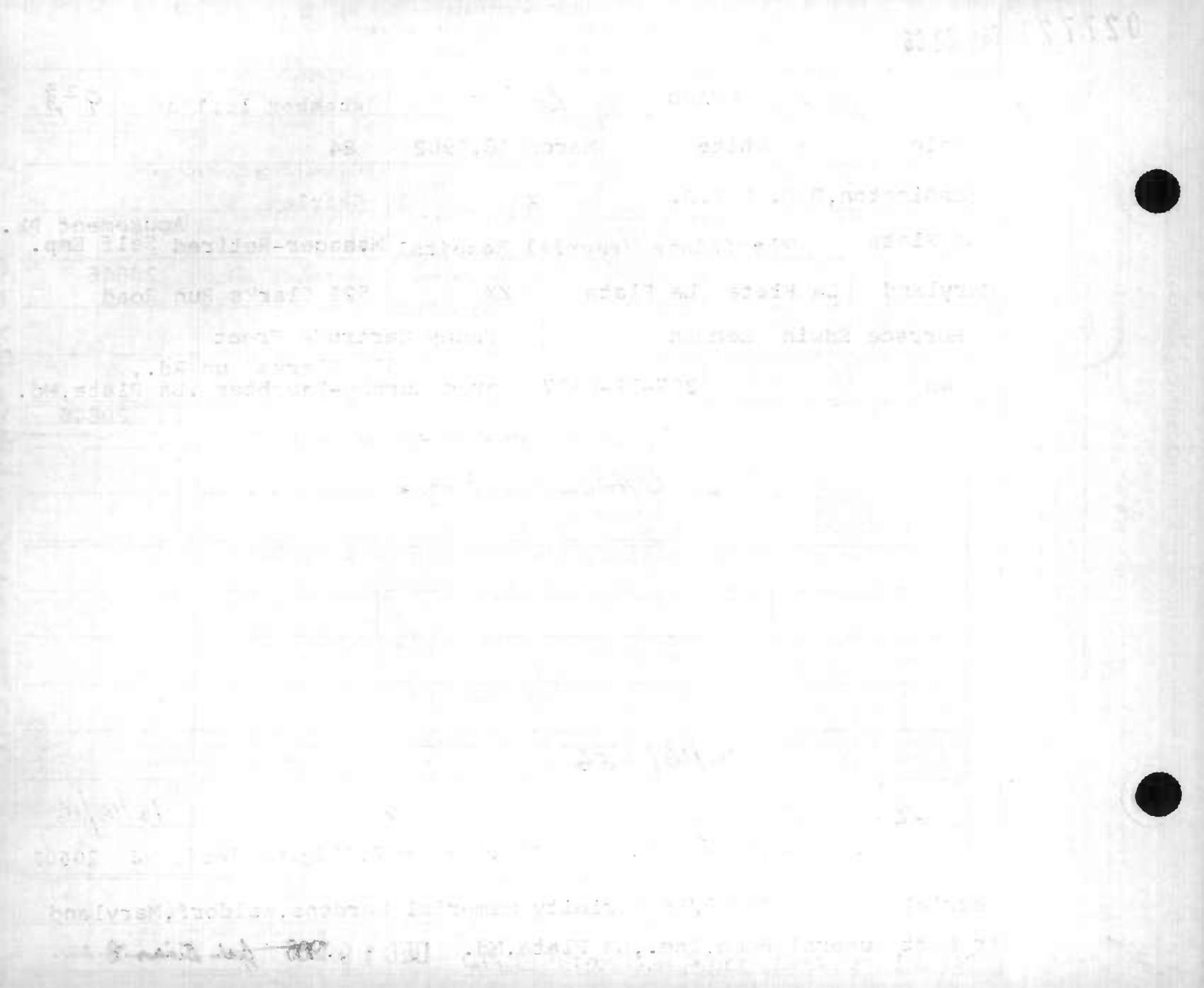
DIVISION OF VITAL RECORDS 201 W. ST. BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED IN 4 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN A PLENTY IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AUGUST WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER CERTIFICATE. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				FIRST Frederick	MIDDLE W ENDELL	LAST King	SR.	2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/>	MONTH 12	DAY 31	YEAR 1986	2b. HOUR 18:46 M		
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH 07	DAY 27	YEAR 30	6. AGE (IN YEARS LAST BIRTHDAY) 56	7. IF UNDER 1 yr. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. IF UNDER 24 HRS. HOURS 0	10. IF UNDER 24 HRS. MIN 0	11. DATE MONTH 12	DAY 31	YEAR 1986		
BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES		
10. CITY OR TOWN OF DEATH LA PLATA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civilian Employee				12b. KIND OF BUSINESS OR INDUSTRY NCS		
13a. STATE MD				13b. COUNTY Charles		13c. CITY OR TOWN Pomonkey		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS Rt. 227			13f. ZIP CODE 20646	
14. FATHER'S NAME FIRST JAMES				MIDDLE		LAST KING		15. MOTHER'S MAIDEN NAME FIRST ENOLIA				MIDDLE LAST SLATER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1952				17. INFORMANT Mrs. Shirley E. King - LaPlata, Md. 20646				ADDRESS Rt. 2 Box 2335		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Ethanol Abuse														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion														
ACTUAL SIGNATURE <i>David N. Gingrich</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 1/1/87								
EXAMINER'S NAME (TYPE OR PRINT) DAVID N. GINGRICH				ADDRESS 5019 Woodhaven Dr. La Plata, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL JAN. 6, 1987		23c. NAME OF CEMETERY OR CREMATORIUM MARYLAND VETERANS CEM.		23d. LOCATION CITY OR TOWN CHELTENHAM		COUNTY P.G.		STATE MARYLAND				
24. FUNERAL DIRECTOR NAME THORNTON'S FUNERAL HOME				ADDRESS POMONKEY, MARYLAND				25a. DATE REC'D. BY REGISTRAR JAN 8 1987		25b. REGISTRAR'S SIGNATURE				

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Report by the hospital or attending physician.

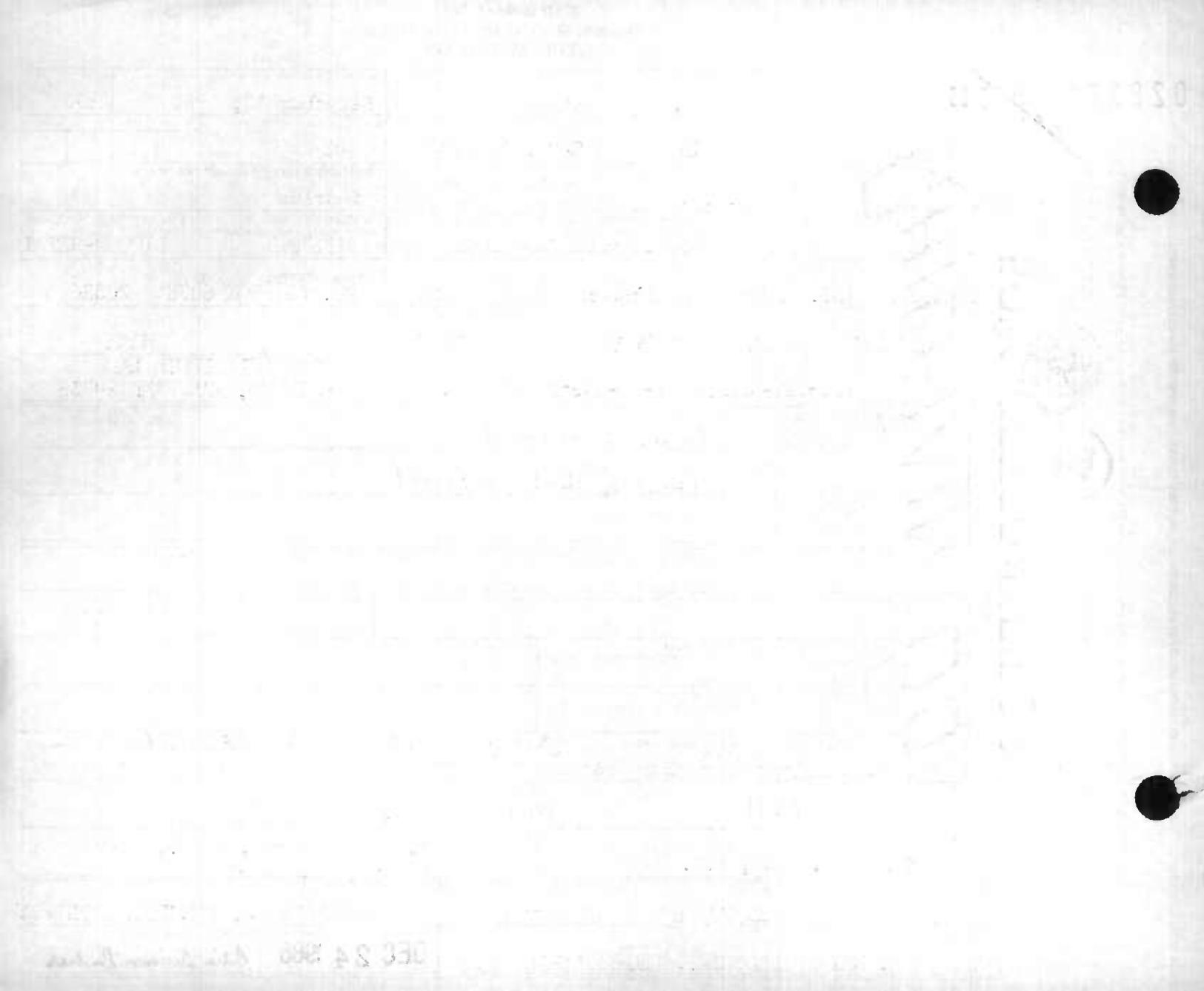
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial permit. Then please return to the hospital or attending physician. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Nolan	MIDDLE E.	LAST Maddox	2a. DATE OF DEATH DECEMBER 18, 1986	MONTH DECEMBER	DAY 18	YEAR 1986	2b. HOUR 1:00 P M	
3. SEX Male	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH SEPT. 6, 1924 DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Charles						MD.		
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN			12b. KIND OF BUSINESS OR INDUSTRY LIQUOR-RETAIL				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14. STATE MARYLAND	14. CITY OR TOWN ST. MARY'S	15. CITY OR TOWN HOLLYWOOD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE RT. #3, BOX 607E 20636					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. W.W. II-KOREA	17. INFORMANT ANITA J. MADDOX	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarct</i>								
			DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
20a. DATE OF OPERATION	20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>July 19</i> to <i>12-18-1986</i> , that (I) (we) last saw the deceased alive on <i>12-18-1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>h. Net</i>			DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Girija S. Rath, M.D.			22e. ADDRESS St. Charles Prof. Bldg., #3200 Waldorf, Md. 20601								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/23/86	23c. NAME OF CEMETERY OR CREMATORIAL ELIZAVILLE	23d. LOCATION CITY OR TOWN ELIZAVILLE, FLEMING, KENTUCKY								
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.	25a. DATE REC'D. BY REGISTRAR DEC 24 1986			25b. REGISTRAR'S SIGNATURE <i>Julia S. Brinsfield, Jr.</i>							



027938 DEC

FOR
STATE
REGISTER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REF. NO

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, RETAIN PAGE 1 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 SHOULD BE HELD WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF FUNERAL RECORDS, 2119 PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3 should be detached for use as the burial/transit permit. Then please return to the attending physician. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

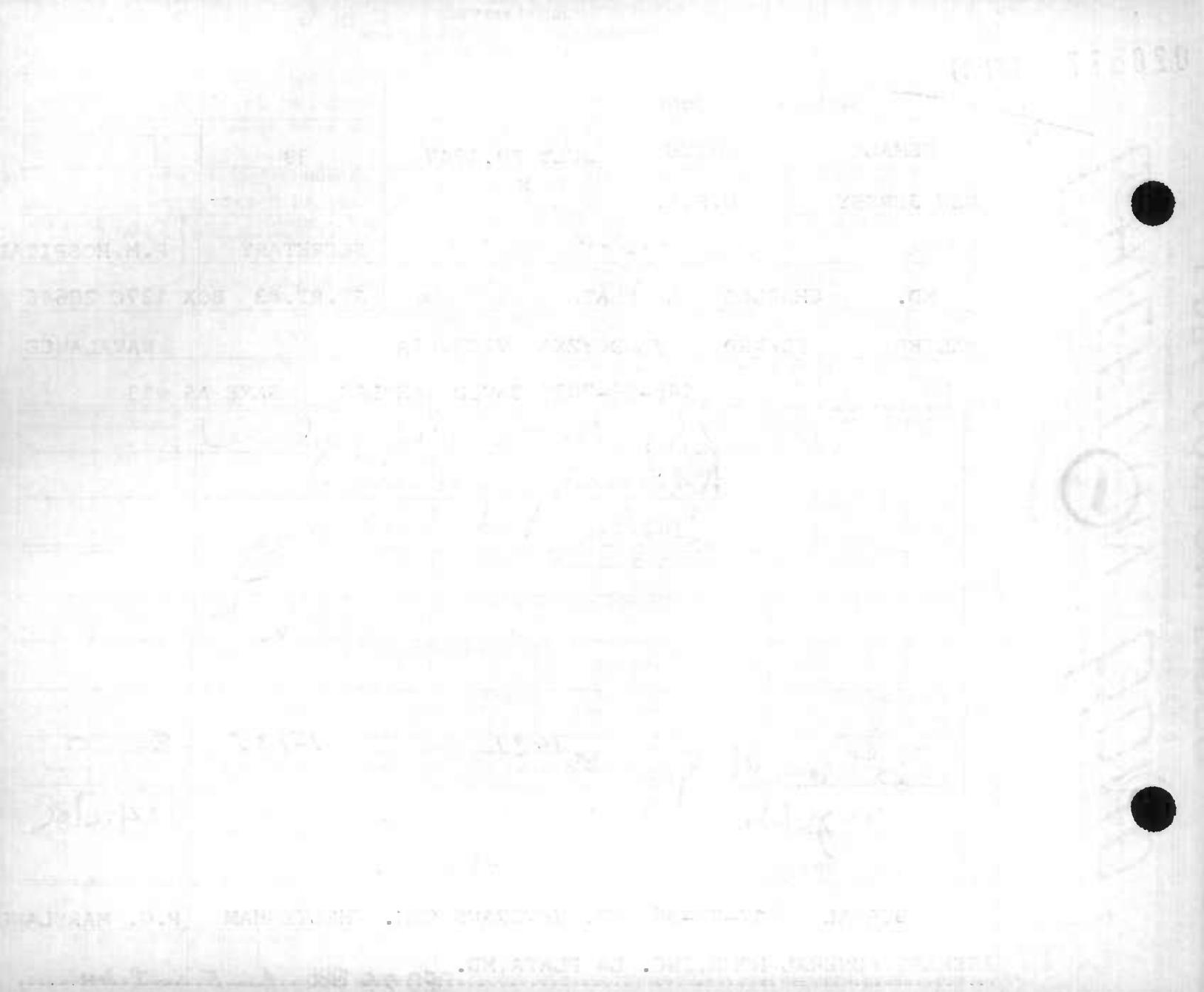
IMPORTANT: If Item 21 is marked (a) - death injury, an off-duty automobile accident, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Barbara			Barbara	Jean	Samoles	December 25, 1986				6:20p M			
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
FEMALE			WHITE	JULY 29, 1947			39			YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.				
NEW JERSEY			U.S.A.										
10. CITY OR TOWN OF DEATH LaPlata			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY			12b. KIND OF BUSINESS OR INDUSTRY P.M. HOSPITAL				
13a. STATE MD.			13b. COUNTY CHARLES	13c. CITY OR TOWN LA PLATA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE ST. RT. #3 BOX 137C 20646					
14. FATHER'S NAME WALTER			MIDDLE EDWARD	LAST SLODCYZKA	15. MOTHER'S MAIDEN NAME VICTORIA			LAST NAVALANCE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 145-36-7021			17. INFORMANT DAVID SAMOLES			ADDRESS SAME AS #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18b. DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Liver Failure.			18c. DUE TO, OR AS A CONSEQUENCE OF (c) Severe internal Bleeding.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12/25/86 to 12/25/86, that (we) last saw the deceased alive on 12/25/86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>George Wathen, M.D.</i>		22c. DEGREE MD.		22d. ATTENDING PHYSICIAN		22e. MEDICAL DIRECTOR		22f. STAFF PHYSICIAN		22g. DATE SIGNED (12/26/86)			
22g. PHYSICIAN'S NAME (TYPE OR PRINT) George Wathen, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-29-86		23c. NAME OF CEMETERY OR CREMATORIAL MD. VETERANS CEM.			23d. LOCATION CITY OR TOWN CHELTENHAM		23e. COUNTY P.G. MARYLAND				
24. FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC.		ADDRESS LA PLATA, MD.		25a. DATE REC'D. BY REGISTRAR DEC 29 1986			25b. REGISTRAR'S SIGNATURE <i>John Wilson, Jr.</i>						
BP _____													
DHMH - 16 60M 7/84 (VRA 15, 4)													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										36 35 34 35					
REG. NO.															
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR						
Joseph Leo Scott, Jr.						December 16 1986			4:23 P.M.						
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS				
Male		Caucasian		Feb. 27, 1928			58		MONTHS DAYS		HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Charles							
Maryland		U.S.A.						MD.							
10 CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shop Foreman		12b KIND OF BUSINESS OR INDUSTRY State Hwy.					
13a STATE Md.		13b COUNTY Charles		13c CITY OR TOWN Pomfret		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Rt. 2, Box 74-K., 20675							
14. FATHER'S NAME Joseph		MIDDLE Leo		LAST Scott, Sr.		15. MOTHER'S MAIDEN NAME Mary		16. SOCIAL SECURITY NO. 218-20-0642		17. INFORMANT Elizabeth Scott, Pomfret, Md. 20675		ADDRESS Rt. 2, Box 74-K			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		17. DUE TO, OR AS A CONSEQUENCE OF (b)			17. DUE TO, OR AS A CONSEQUENCE OF (c)										
18. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)															
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a I certify that (I) (this hospital) attended the deceased from 3-17, 1982, to 12-16, 1986, that (I) (we) last saw the deceased alive on 10-24, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					22b SIGNATURE Khadar Baig, M.D.		DEGREE M.D.		22c DATE SIGNED 12/16/86						
22d PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS 108 LaGrange Ave., LaPlata, Md. 20646										
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial		23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's Cem.			23d. LOCATION CITY OR TOWN Pomfret, Charles		COUNTY		STATE				
24 FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Md. 20601		ADDRESS			25a DATE REC'D. BY REGISTRAR DEC 19 1986		25b. REGISTRAR'S SIGNATURE John Tisdale, Director								
BP															

80 35001

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR

DECEASED NAME Steven Gerard Shryock
MIDDLE NAME Gerard Shryock

2a DATE KNOWN
OF
DEATH MATED
MONTH DAY YEAR
12 24 19 86
2b HOUR
5:00 M

1. SEX M 4. RACE W 5. DATE OF BIRTH
MONTH DAY YEAR
10 9 55 6. AGE (IN YEARS
LAST BIRTHDAY)
YRS. 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN
31 0 0 0 0

2c. DATE
PRONOUNCED
DEAD
MONTH DAY YEAR
12 24 19 86
2d. HOUR
5:00 M

6. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED NEVER MARRIED
WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH
Charles MD

10. CITY OR TOWN OF DEATH
La Plata

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Physicians Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Electrician

12b. KIND OF BUSINESS
OR INDUSTRY
Electric

13. MUNICIPAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland 13b. COUNTY St. Mary's 13c. CITY OR TOWN Charlotte Hall 13d. INSIDE CITY LIMITS? NO 13e. STREET ADDRESS
Rt. 1 Box 395/ 20622

14. FATHER'S NAME
FIRST Charles MIDDLE LAST Shryock Jr. 15. MOTHER'S MAIDEN NAME
FIRST Charlotte MIDDLE LAST Frances Yoder

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO 16b. SOCIAL SECURITY NO. 214-70-2455 17. INFORMANT
Gail Y. Shryock same as # 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8199 IMMEDIATE CAUSE (a) MVA asphyxiation
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to the immediate
cause (a) stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4 P.M. 24 OLY 19 86	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>MVA</u>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>street</u>	21f. LOCATION STREET <u>Rt 231</u> CITY OR TOWN <u>Hughesville</u> COUNTY <u>Charles</u> STATE <u>Md</u>

22a. I certify that I took charge of the remains described above, held an Autopsy Inspection and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE H M Haff M.D. Charles G MEDICAL EXAMINER
DATE SIGNED 12/24/86

EXAMINER'S NAME (TYPE OR PRINT) H M Haff ADDRESS 1020 Darley Dr. Laffah Md 20696

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION CITY OR TOWN
Burial 12-30-86 St. Mary's Bryantown Chas. Md.

24. FUNERAL DIRECTOR NAME Huntt Funeral Home ADDRESS P. O. Box 156 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
(VR A15 ME (5)) Waldorf, Md. 20601 DEC 29 1986 Julia Tindall-Bradley
20M 4/B2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										30 35 0 28			
1. FOR STATE REGISTRAR			2a. FIRST MIDDLE LAST			2b. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 10:53 P.M.				
1 DECEASED NAME (TYPE OR PRINT)			Rose Raymond Soares			December 8, 1986							
3 SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH MARCH DAY 19, 1904 YEAR			6. AGE (IN YEARS FIRST BIRTHDAY) UNDER 1 YEAR MONTHS 82 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FALL RIVER, MASS.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.				
10. CITY OR TOWN OF DEATH LaPlata			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SPINNER			12b. KIND OF BUSINESS OR INDUSTRY TEXTILE IND.				
13a. STATE MARYLAND			13b. COUNTY CHARLES			13c. CITY OR TOWN INDIAN HEAD			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST DAMASE			LAST RAYMOND			15. MOTHER'S MAIDEN NAME FIRST CELINA			16. ADDRESS LAST TREHAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO			16b. SOCIAL SECURITY NO. 026-03-8777			17. INFORMANT VICTOR F. SOARES			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a arteriosclerosis, hypertension, anemia													
19a. DATE OF OPERATION n/a			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED n/a			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2 n/a							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, ETC.) n/a			21f. LOCATION STREET n/a			CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>11/30/86</u> to <u>12/7/86</u> , that (1) (we) last saw the deceased alive on <u>11/30/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Dr. Paul Pritchett MD										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Paul Pritchett										22e. DATE SIGNED 12/9/86			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-12-86			23c. NAME OF CEMETERY OR CREMATORIAL ST. PATRICK'S CEM. SOMERSET			23d. LOCATION CITY OR TOWN COUNTY STATE MASS.				
24. FUNERAL DIRECTOR NAME HATHAWAY FUNERAL SER. FALL RIVER, MASS.										25a. DATE REC'D. BY REGISTRAR DEC 11 1986			
										25b. REGISTRAR'S SIGNATURE John M. Pritchett			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician, it should be detached for use as the burial/transit permit. Then please remember to return the certificate to the State Dept. of Health and Mental Hygiene prior to burial or cremation. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner/mortuary should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 35327	
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Stephen Joseph Sterbanis						December 13, 1986			10:08 p _m		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		Sept. 26, 1917		69			YRS.		
7b. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
Pennsylvania		U.S.A.				Charles			La Plata		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Physicians Memorial Hospital										Farmer-Retired Farming	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Cobb Island		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE General Delivery 20625		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Peter Sterbanis		Mary Cartic									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		220-34-3559		Lillian Irene Sterbanis-Wife		Same as # 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) ACUTE MYOCARDIAL INFARCTION	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/12/86 to 12/13/86, that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED	
22b. SIGNATURE Rama Krish		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nallan Ramakrishna, M.D.		22e. ADDRESS Waldorf, Md. 20601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/17/86		23c. NAME OF CEMETERY OR CREMATORIAL Holy Ghost Cemetery Issue, Charles Co., Md.		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Md.		25a. DATE REC'D. BY REGISTRAR DEC 17 1986 25b. REGISTRAR'S SIGNATURE Julia Darden-Randall									

primary ventilation

ventilation pressure, ΔP = $P_{\text{ex}} - P_{\text{in}}$

breath hold time

breath hold time = $\Delta P \cdot V_{\text{exp}} / \dot{V}_{\text{exp}}$

breath hold time = $\Delta P \cdot V_{\text{exp}} / \dot{V}_{\text{exp}}$

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breath hold time = $\Delta P \cdot V_{\text{exp}} / \dot{V}_{\text{exp}}$

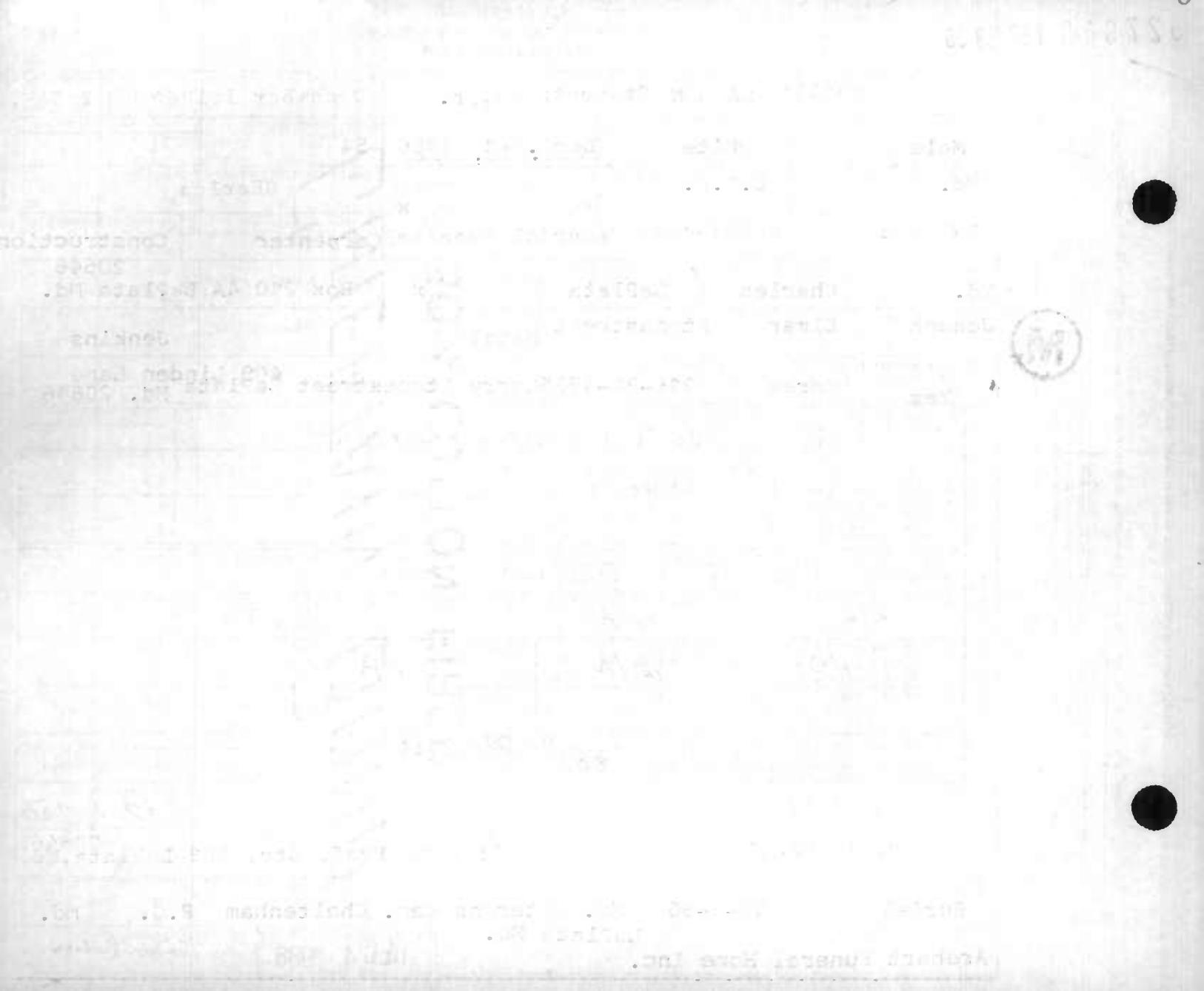
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified to the funeral director, it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 is checked, any injury, or other traumatic event, the medical examiner

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR			
Philip LAWSON Stonestreet, Sr.			December 1, 1986		2:54 P.M.			
3. SEX Male		4. RACE White	5. DATE OF BIRTH OCT. 18, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 54			
7a. BIRTHPLACE Md. (State)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles		
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Physicians Memorial Hospital		12a. USUAL OCCUPATION Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. STATE Md.		13b. COUNTY Charles	13c. CITY OR TOWN LaPlata	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE Box 210 4A LaPlata Md. 20646		
14. FATHER'S NAME Joseph		15. MOTHER'S MAIDEN NAME Elmer Stonestreet Mabel		16. ADDRESS 409 Linden Lane LaPlata Md. 20646		LAST NAME Jenkins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea 216-30-4735		17. INFORMANT Larry Stonestreet		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i>								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>chronic Obstructive Pulmonary Disease</i>								
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II) N/A				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>11-21-1986</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>11-21-1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Dr. A. Fadul</i>		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12-2-986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Fadul		22e. ADDRESS LaPlata Prof. Ctr. 202-LaPlata, Md., 20646						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-5-86		23c. NAME OF CEMETERY OR CREMATORIAL Md. Veterans Cem.		23d. LOCATION CITY OR TOWN Cheltenham		
24. FUNERAL DIRECTOR NAME Arehart Funeral Home Inc.		ADDRESS LaPlata Md.		25a. DATE REC'D. BY REGISTRAR DEC 4 1986		25b. REGISTRAR'S SIGNATURE Julia Darden-Landale		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

29426 JAN-687

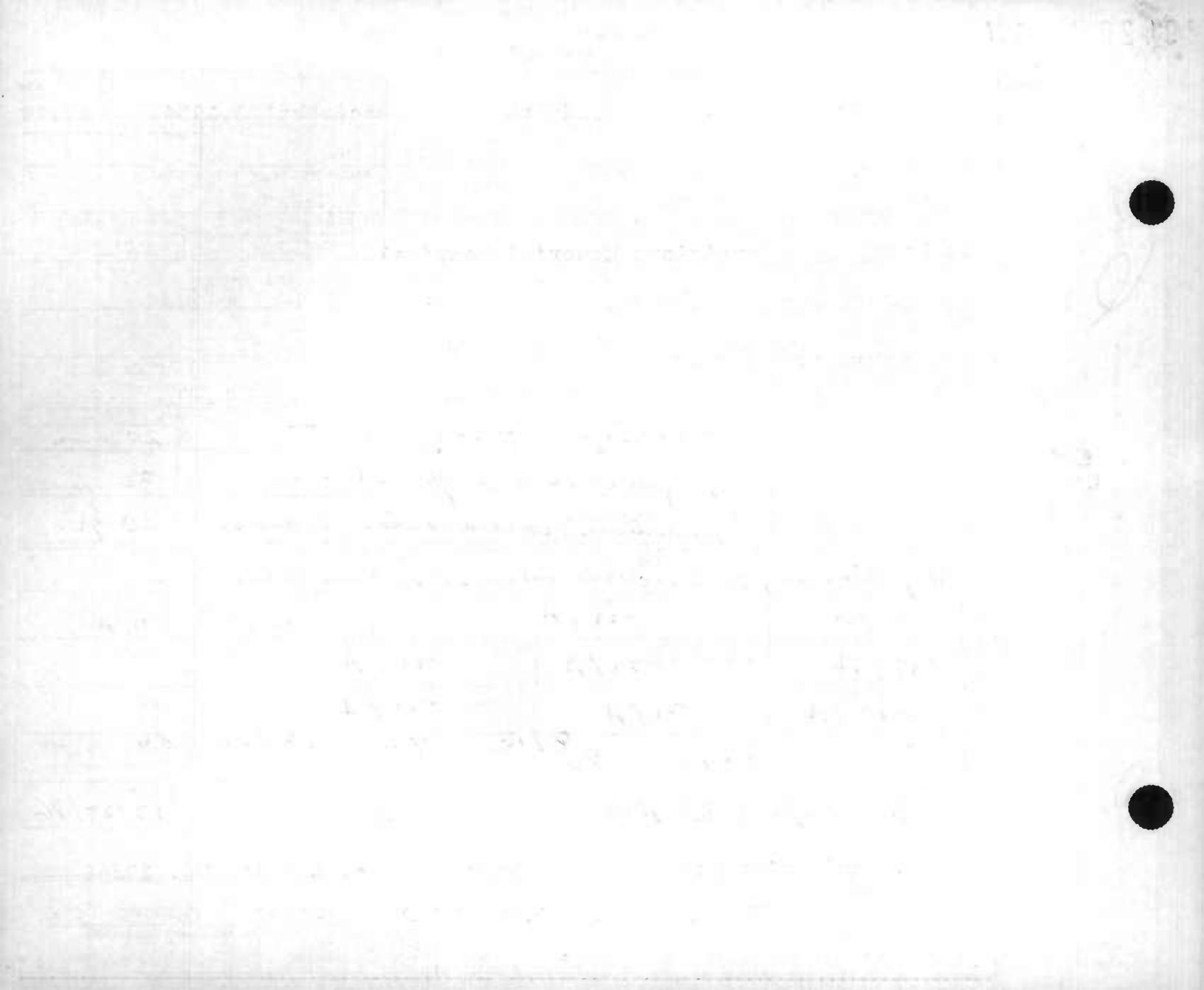
1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR							
Agnes C. Swann						December	23, 1986			AM 12:18							
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)										
FEMALE			BLACK	MAY	13	1926	60	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
MARYLAND			UNITED STATES				CHARLES			MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
LaPlata			Physicians Memorial Hospital			HOMEMAKER			PRIVATE								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE					
13a. STATE MARYLAND		13b. COUNTY CHARLES		13c. CITY OR TOWN PISGAH		ROUTE 425 / 20640											
14. FATHER'S NAME FIRST ROBERT			MIDDLE QUILLAN			LAST CARTER			15. MOTHER'S MAIDEN NAME FIRST VICTORIA			MIDDLE ELIZABETH		LAST QUEEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			N/A			220-16-4914			JOYCE BRISCOE			2180 Arbor Lane Bryans Road, Md. 20616			20 min		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Cardiopulmonary arrest											
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction						30 min					
						DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension cardiovascular disease						20 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Hypertension, Atherosclerosis, thromboembolic disease																	
19a. DATE OF OPERATION n/a		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED n/a			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED n/a			21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ARM, ETC.) n/a			21f. LOCATION STREET n/a			
														CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/16, 1972, to 12/22, 1986, that (I) (we) last saw the deceased alive on 12/21, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Dr. Paul Pritchett MD														DEGREE		22c. DATE SIGNED 12/25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS											
Dr. Paul Pritchett						LaGrange Ave, LaPlat, Md. 20646											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE							
BURIAL		DEC. 27, 1986		ST. CHARLES CEMETERY		GLYMONTE		CHARLES		Md.							
24. FUNERAL DIRECTOR NAME THORNTON'S FUNERAL HOME						24a. DATE REC'D. BY REGISTRAR DEC 30 1986						25b. REGISTRAR'S SIGNATURE John R. Rodger					
ADDRESS POMONKEY, Md.																	

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove from the papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN LINE 18, WITH FORM P.M. 3, RETAIN PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, 201 W. PRESTON ST., BALTIMORE, MD. 21201. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR Cremation.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35332					
DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN <input type="checkbox"/> OF DEATH ESTI- MATED <input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR 12 th 1986 3:16 P.M.	
3 SEX M			4 RACE W			5 DATE OF BIRTH MONTH DAY YEAR 15 31 55			6 AGE (IN YEARS (LAST BIRTHDAY) YRS.			IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD 12 th 1986 3:16 P.M.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			7b CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co., MD								
10 CITY OR TOWN OF DEATH Waldorf			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 711 Barrington Drive			12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE) Chief Engineer			12b. KIND OF BUSINESS OR INDUSTRY P.G. Schools								
13a. STATE Maryland			13c. CITY OR TOWN Waldorf			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 711 Barrington Dr. 20601								
14. FATHER'S NAME Lewis			15. MOTHER'S MAIDEN NAME Mary			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 246-42-1755			17. INFORMANT Veronica Taylor 2229 14th St. SE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/5-		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CAD ASCVD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED 12/4/86					
ACTUAL SIGNATURE H M Heff			M.D. Charles C. MEDICAL EXAMINER			ADDRESS 1020 Darley Dr. LaPlata MD 20646											
EXAMINER'S NAME H M Heff MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-09-86			23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Cemetery			23d. LOCATION CITY OR TOWN Winston-Salem			COUNTY	STATE NC				
24. FUNERAL DIRECTOR NAME Robert G. Mason			ADDRESS 1661 Good Hope Rd, SE			25a. DATE REC'D. BY REGISTRAR DEC 5 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandale								
(VR A15 ME (5))																	

15830-10-30

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James MILTON			2a. DATE OF DEATH December 8, 1986	MONTH YEAR	2b. HOUR 4:06 PM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH August DAY 4 YEAR 1929	6. AGE (IN YEARS LAST BIRTHDAY) 57	IF UNDER 1 YEAR MONTHS YRS. DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH LaPlata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER - PLUMBER	12b. KIND OF BUSINESS OR INDUSTRY PRIVATE
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY CHARLES	13c. CITY OR TOWN NEWBURG	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Box 175 / 20664	
14. FATHER'S NAME FIRST JOSEPH MIDDLE LAST THOMAS			15. MOTHER'S MAIDEN NAME FIRST CARRIE MIDDLE L. LAST MOORE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (ENTER IN WAR ORDERS) 1951-1953 218-26-6853		17. INFORMANT ADDRESS Jacqueline Thomas 1023 Quebec St. # 6 Arlington, Virginia 22204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIO-PULMONARY ARREST</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF EOSOPHAGUS</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. 8 MONTH 28 DAY 56 YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>8-28-86</u> , 19 <u>86</u> , to <u>12-8-86</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12-8-86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>KRISHAN M. MATHUR</u>	22c. DEGREE <u>MD</u>	22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED <u>11-9-86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KRISHAN M. MATHUR		22e. ADDRESS 17 MARSHALL Rd Waldorf, Md. 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12-13-86	23c. NAME OF CEMETERY OR CREMATORIAL HOLY GHOSTCHURCH	23d. LOCATION CITY OR TOWN ISSUE	23e. COUNTY CHARLES	23f. STATE MARYLAND
24. FUNERAL DIRECTOR NAME THORNTON'S FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR 15 1986	25b. REGISTRAR'S SIGNATURE Julia Darden Rader	
ADDRESS POMONKEY, Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN. The services rendered by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached to the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death.

THE INFLUENCE OF THE ENVIRONMENT ON THE GROWTH OF COTTON 113

BP _____

0500 1000 1500

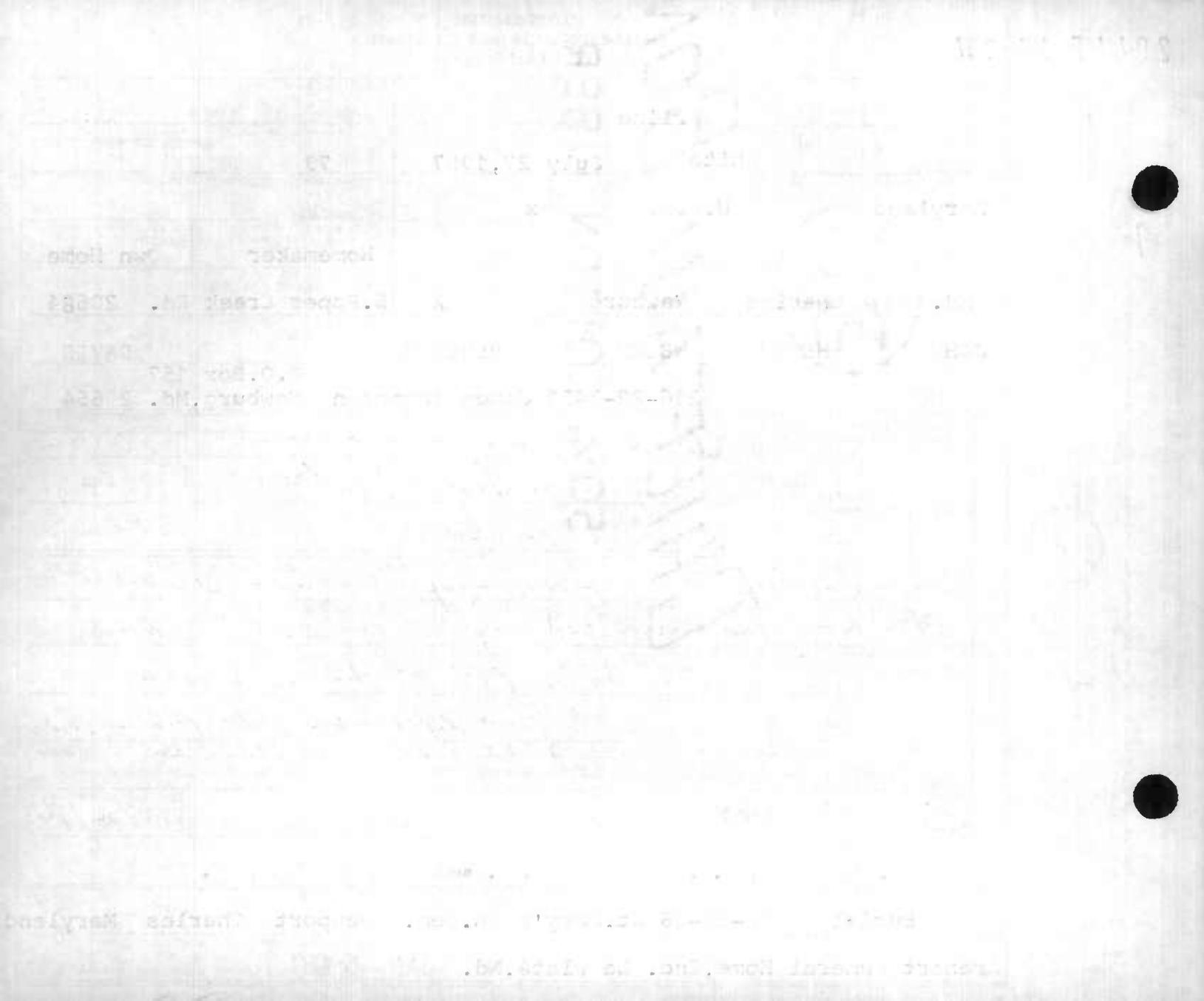
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this death certificate has been signed by the funeral director, page 3 should be detached for use in the funeral permit. Page 4 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene office, Bureau of Vital Statistics, or removal. IMPORTANT: If item 18 is marked as 'No' the death may be certified by the attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Alice			Arline Thompson	December 28, 1986				11:10 P	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 27, 1907		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	79	YRS				
8. MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Charles						
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Md.	13b. COUNTY Charles	13c. CITY OR TOWN Newburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE S. Popes Creek Rd. 20664				
14. FATHER'S NAME FIRST JOHN	MIDDLE HENRY	LAST WELCH	15. MOTHER'S MAIDEN NAME FIRST REBECCA		MIDDLE	LAST DAVIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 216-22-3421	17. INFORMANT James Thompson	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 888 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		ADDRESS P.O. Box 157 Newburg, Md. 20664		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min		
		(b) <i>Congestive Heart Failure</i>				5 days			
		(c) <i>Renal failure</i>				10 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Urinary Tract infection, sepsis, Hypotension, Decubitus ulcer</i>									
19a. DATE OF OPERATION 12/26/86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture left leg			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11 25 1986	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) fell at home, 2:00 A.M.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home	21f. LOCATION STREET South Popes Creek Rd Newburg, Charles, Md	CITY OR TOWN Newburg	COUNTY Charles	STATE Md.				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/9/25</u> , 1974, to <u>12/27</u> , 1986, that (I) (we) last saw the deceased alive on <u>12/28</u> , 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Paul E. Pritchett</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/29/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul E. Pritchett, M.D.	22e. ADDRESS P. O. Box 1317, La Plata, Md. 20646								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-31-86	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Ch. Cem.	23d. LOCATION CITY OR TOWN Newport	23e. COUNTY Charles	23f. STATE Maryland				
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.	ADDRESS La Plata, Md.	25a. DATE REC'D. BY REGISTRAR JAN 5 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Dudson-Randall</i>					



026888 DEC

FOR
42 STATE
PREFECTURE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2. *Leucosia* (Leucosia) *leucosia* (Linnaeus) (Fig. 1)

REG NO

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN A COPY FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE HELD UNTIL 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, RADMORF, MARYLAND, AND 21201 PRIOR TO RUDIAL Cremation OR REMOval ON STREET.

DIVISION OF VITAL RECORDS, 281 W. PRESSEY ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT) MARY Mart					FIRST MARY	MIDDLE Christine	LAST Thompson	WEBB	2a. DATE KNOWN OF ESTI- DEATH MATED 12 8 1986	MONTH 12	DAY 8	YEAR 96	2b. HOUR 5:30 PM	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH 11	DAY 3	YEAR 27	6. AGE (IN YEARS LAST BIRTHDAY) 59	7. IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD 12 8 1986	MONTH 12	DAY 8	YEAR 96	2d. HOUR 5:30 PM
BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Charles						
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator			12b. KIND OF BUSINESS OR INDUSTRY Groc. Store						
13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia					13b. COUNTY Carroll	13c. CITY OR TOWN Hillsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt-58 / 24343 9999						
14. FATHER'S NAME FIRST James					MIDDLE Emmett	LAST Thompson	15. MOTHER'S MAIDEN NAME FIRST Gracie	MIDDLE Ella	LAST Sutphin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 231-24-9665			17. INFORMANT Silas Asa Webb (Husb)			ADDRESS -same as #1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD COPD										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years				
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion														
ACTUAL SIGNATURE H M Haft EXAMINER'S NAME (TYPE OR PRINT) H M Haft MD TITLE (SPECIFY) Charles K M.D. MEDICAL EXAMINER ADDRESS 1020 Darley Dr. LaPlata MD 20680 DATE SIGNED 8 Dec 86														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/11/86		23c. NAME OF CEMETERY OR CREMATORIAL Webb Cemetery			23d. LOCATION CITY OR TOWN Hillsville, Carroll, Va.		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		ADDRESS Waldorf, Md 20601		25a. DATE REC'D. BY REGISTRAR DEC 11 1986			25b. REGISTRAR'S SIGNATURE Julia Sanderson Landau							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return certificate. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 26 shows any injury, an other traumatic event, the medical certificate must be completed.

MEDICAL CERTIFICATION

I. DECEASED NAME				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
CLARA				MA	Y	WOODY	12-28-86				1:30 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
FEMALE		WHITE		MONTH NOV. DAY 10, YEAR 1892			94			MONTHS	DAYS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		U.S.A.					CHARLES			MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
PORT TOBACCO		P.O. BOX 325		LUSHLAND FARM			HOMEMAKER			OWN HOME			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13b. STATE	MD.	13b. COUNTY	CHARLES	13c. CITY OR TOWN	PORT TOBACCO	13d. INSIDE CITY LIMITS?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	P.O. BOX 325	20677		
14. FATHER'S NAME		FIRST	WILLIAM	MIDDLE	WILSON	LAST	ELLEN	MIDDLE	MAY	LAST	OVERTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR GATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO				215-03-1954			GERTRUDE MITCHELL			P.O. BOX 2027 LA PLATA, MD. 20646			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>ATRIAL FIBRILLATION</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/>		NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE		
22a. I certify that <input checked="" type="checkbox"/> (1) this hospital attended the deceased from <u>11</u> to <u>19 86</u> , and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (1) <input type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.						19		12-28, 19 86					
22b. SIGNATURE						DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		HENRY L. BURKE M.D.				22e. ADDRESS		LA PLATA, MD.				12-28-86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION		CITY OR TOWN			COUNTY	STATE
BURIAL		12-30-86		LORRAINE PARK CEM.			BALTIMORE		MARYLAND				
24. FUNERAL DIRECTOR		NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
		ABE HOOT FUNERAL HOME INC.		LA PLATA, MD 20677			JAN 02 1987		John Burke, Jr.				

